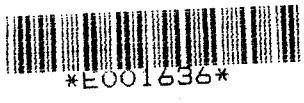
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2nd

DIVISION OF REGIONAL MEDICAL PROGRAMS

AD HOC REVIEW COMMITTEE

- - -

PANEL "A"

- - -

Conference Room G/H,
Parklawn Building,
5600 Fishers Lane,
Rockville, Maryland, 20852,
Wednesday, May 22, 1974.

- - -

PRESIDING:

CLEVELAND R. CHAMBLISS, Acting Deputy Director.

PRESENT:

MRS. FLORENCE WYCKOFF
DR. PHILIP WHITE
DR. WILLIAM VAUN
MR. ROBERT TOOMEY
MR. JOHN THOMPSON
DR. ROBERT SLATER
MRS. JESSE SALAZAR
DR. WINSTON MILLER
DR. ALEXANDER McPHEDRAN
DR. ROBERT CARPENTER

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C O N T E N T S

(continued on next page)

CONTENTS

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P R O C E E D I N G S

MR. CHAMBLISS: Let me take this opportunity to call Panel "A" to order and welcome you here to this particular work group.

I think you should know that as we get into our procedures for the next day or so that I will have at my right and at my left two Operations Branch chiefs, Mr. Lee Van Winkle, who is the Operations Chief for the South-Central Operations Branch of the Division of Operations and Development, and Mr. Mike Posta, who is the Operations Branch Chief for the Mid-Continent Operations Branch.

I think the panel should know that we had expected, as Dr. Pahl mentioned, Mrs. Silsbee to have chaired this panel and it's due to her illness that I've been asked, just in the last few hours, to chair the panel.

Dr. Pahl and I, as he mentioned, have been looking at other things over the last eighteen months and especially these matters having to do with OMB questions, with answering questions from the Department dealing with the congressional relations, all the questions coming from the Congress having to do with the phase-out and the status of the program, the inter-agency aspects of operating the program, and both of us have left all but entirely the operational aspect of operating the division to Judy, who has, I might say, served with great distinction.

When the annals of RMP are written, she will truly be one of the strong people of RMP, a great person, a great lady, a prodigious worker, and a good friend to all of us.

Hopefully she will be here while these proceedings are underway, but Mike and Lee will provide me with lateral support, and at the same time we will have support from members of the Operations Staff and also a representative from the Grants Management Staff in the person of Mr. Larry Pullen.

I think the committee is well-aware of the fact that we are operating under a court order and I will only say one additional thing: Dr. Endicott said that things are a mess; I agree. I will only add my word of wisdom, if you can call it that, and that is, we have lived in a chaotic community over the past few months and this, in a way, culminates some of the trials that we have undergone by reviewing the applications from the regions that came in on May 1st, their application for funding beginning July 1, '74.

I think, as we get underway, you should know we will be operating under the Mission Statement that we all know so well. We are operating under no restrictions as relates to the program activities of the RMPs.

And maybe I at this time should call upon Lee Van Winkle to just set forth in highlight fashion some of the review guide procedures that we'll be utilizing.

Lee, won't you --

MR. VAN WINKLE: I just primarily want to call your attention to the review guides that you have, and I know that Dr. Pahl said it earlier, but I think it should be repeated that I think this group has to focus on the over-all program of the Region and the proposal as submitted rather than on a technical review of the individual projects, and we do have the criteria listed.

I think the only other thing that I want to mention at all is the review sheet that you find attached in there. We will expect the two reviewers to fill that out and we'll collect those as we go along.

DR. MILLER: When do you want them?

MR. VAN WINKLE: Sir?

DR. MILLER: When do you want them?

MR. VAN WINKLE: We'll give you time to complete them --

MR. CHAMBLISS: At the end of each review as we sit here.

DR. MILLER: As we sit here?

MR. VAN WINKLE: Yes. Before we go to the next application, we would like you to fill it out -- in talking with Miss Leventhal -- and pick it up at that time.

DR. SLATER: I want to have some time to rewrite my commentary on those, so I'll get it back to you during this session, but it won't be immediately after my oration.

MR. CHAMBLISS: Thank you, Lee.

I should mention that, as you have probably noted in some of the background materials, that the focus of the review will, by and large, touch on about eight elements.

The first is program leadership; second, program staff; third, regional advisory group; four, past performance and accomplishments of the region; five, the region's objectives and priorities; six, the proposal; seven, feasibility; and eight, and finally, CHP relationship.

I think one additional item of procedure may be in order here, and it's a further elaboration on the focus for review. Dr. Pahl mentioned that the policy issues would simply be flagged and we would not necessarily attempt to resolve them here; that the target amount should be the principal benchmark for a backdrop for the review.

Lee has mentioned that the two reviewers will review and the second reviewer will simply add additional comments or observations.

We hope to follow the exception principle if we are really going to get through in our appointed time.

We also will have Staff comments as necessary and required and for each of the regions under review the Staff person handling that particular region will be at the head table here.

After that, a brief discussion, and we will attempt

to clarify any items or matters that need to be clarified, looking forward to the presenter giving us a recommendation and the rationale for his recommendation, ending up with a motion on that particular recommendation, and from there we will ask each reviewer to complete the rating sheet as we've touched on.

There are applications at the back table, complete applications on the back table, for each of the reviewers who will need them, and we would simply ask you as a final matter of procedure, kindly speak into the microphone so that our recorder can get all of the details.

Are there any questions at this moment before we begin to proceed?

Dr. Vaun?

DR. VAUN: I've heard Lee refer a couple of times to the fact that we're not going to do a technical review, if I understand what he's saying. However, I'd like to know how we're going to reach a judgment about funding levels unless we address some of the technical aspects of the programs.

On the basis of the guidelines submitted, namely, leadership, past performance, it's going to be very difficult to arrive at a funding level.

Lee, how do you want us to work this magic if we're not going to look at the projects?

MR. VAN WINKLE: Well, I think that you do have to

look at the projects because that's a part of the total proposal that came in, and if what you see in here is not related to the goals and objectives of that region, then I think you have real cause for concern, and certainly if there are items included in here that are strictly against policy of the Regional Medical Program, that also has to come out.

But I think you have to look at what they've submitted, the individual pieces; but as to getting into the individual technical aspects of a particular activity, that's what we're trying to avoid.

DR. VAUN: Okay.

MR. VAN WINKLE: The actual makeup of that activity that you're looking at.

MR. CHAMBLISS: Let me just add one additional piece of information so that we have something of a framework. The panel will have a total of 28 applications to review with a requested amount of $65.5 million. There's one continuation request; there are 23 continuation and new activity requests; there are 24 additional applications expected from this set of regions in July.

Twelve of the regions that you will be reviewing have had -- twelve of the twenty-eight -- have had new coordinators since the phase-out was announced. There have been limited site visits. However, there have been Staff visits to nineteen of the regions in question. Two have had review

certifications; six have had management surveys; and twelve others have had technical assistance visits.

So there is a body of intelligence residing in the Staff as to how the regions are functioning and operating. I thought you would like to have that just as a backdrop.

MR. VAN WINKLE: Can I add just one thing?

MR. CHAMBLISS: Yes.

MR. VAN WINKLE: Dr. Vaun, I think what we're seeking here is the development of a level of funding and not a funding level -- level of approval, if you will, not funding level, and the funding level actually will be determined somewhere within that level of approval.

If you come in, let's say, with a leval of approval on one program at $2 million, the actual funding level will be made up to that figure, it won't exceed it, and it may be less than that.

DR. SLATER: Could I --

MR. CHAMBLISS: Dr. Slater.

DR. SLATER: May I make a point? I, like you, have been trying to get a grasp on this in comparison to the old days and, furthermore, in the light of what Mr. Rubel is talking about, and I have the same concern that you have, that while not really examining these projects which are presented in variable detail from one region to another, I'm attempting to make some kind of an assessment, really, to give you, in a

sense, professional backup as to what kind of funding these regions should have.

Coming through to my mind all the time is the fact that since we're apparently going through such major changes in the next few years in which RMP will be recast in some way or the other that what we're here to do, really, is to just look for the most obvious problems or errors which you as Staff have to correct in order to justify the expenditure of these funds and that we're not going to vary, really, very much from the figures you have here, because the most important role we have to play now in this interim period is to stabilize those staffs out there in order that one has a group of people that are well-trained and indoctrinated to move ahead in some fashion in the years ahead.

So I must say I don't have too much difficulty making assessments. I'm having to rely so much on what they've already decided to do there, that I think we're really here just to provide professional extramural moral support more than anything else -- obviously, there are going to be some holes in that, but, generally speaking, that's how I read it.

MR. CHAMBLISS: I assure you we need that, too, but we do need your professional judgment.

DR. SLATER: I agree.

MR. CHAMBLISS: And we need your views and we would

like you to work on the exception principle. If there are matters that are exceptions of policy issues, then we would like to have your judgment on them.

DR. SLATER: I'm not trying to be soft, but what I am concerned about is that with the stability of the staff and the projects and all they mean out there is perhaps the most important element in the survival of the whole pattern of activity that was started eight or ten years ago.

MR. CHAMBLISS: Mr. Thompson.

MR. THOMPSON: On the interface with kidney, EM -- emergency medical services, and PSRO, did the Staff go through and edit any of these in any way, identify those projects that are obviously in conflict with kidney, emergency, and PSRO?

MR. CHAMBLISS: We have in fact gone through all the requested project activities and have seen -- attempted to determine if there was a conflict with the policies of another program. We have also had discussions with the key staffs of the kidney program, the emergency medical services program, and they will give us some assistance in these reviews where we find conflicts.

A number of these activities, the regions have been into actually before some of the legislation was passed -- quality assurance, which borders very closely to PSRO, and so on -- and those activities are being continued.

However, in the case of EMS, you should know that it

is a program decision and a matter of statute that the RMPs or no other program will enter into EMS activities so as to build a system of emergency medical care.

Our regions have had facets of a system and, therefore, with the understanding that we have between EMS and RMP, those activities are permissible for funding under this set of applications, so their basis -- they are not designed to produce total systems.

MR. THOMPSON: But maybe the problem is that if you put money into those nobody will ever be able to design a total system because those pieces will be out, you can't pick them up.

MR. CHAMBLISS: Well, at the local level the CHP agencies have been coordinating to see how the RMP proposal fits into the total need at the local level, so there has been a degree of coordination and cooperation there to make sure that the pieces that we support have some relevance to what else is going on.

MR. THOMPSON: But I detect something in the applications I read, which, although it is not in direct conflict with the PSRO organization, it is obviously addressed to the tactic that hospitals, if they have any brains, have suddenly got to realize that they've got to get their own quality assurance program, optioning (phonetic) subbing it out to a PSRO or do it themselves, and some of these projects are

asking for money to let hospitals build up their own quality assurance programs so they can eventually do this for PSRO.

I object to it for two reasons. One is they should have been paying attention to quality a long time ago -- all of a sudden they shouldn't have discovered the wheel. But this isn't related to PSRO --

MR. CHAMBLISS: Indeed it is. As a matter of policy, Council policy, we have stated many times that the RMPs could not become involved in PSRO development per se; they could not use their funds for the operational aspects of a PSRO.

DR. McPHEDRAN: They could be involved in development?

MR. CHAMBLISS: They could not be involved in the actual development, but that if there were studies, data collection or peripheral activities related to quality assurance, that they could be involved in that using RMP funds.

MR. VAN WINKLE: I'd like to add one comment. As far as the Staff comments you find in here, they have flagged items for your attention, items that they felt were of concern that they wanted to be sure that you looked at.

Now, they haven't made any recommendation on those to the committee. They've left that up to the committee.

And in looking at the criteria that you're going through as far as leadership, RAG, and all of these items, I want to assure you that the Staff have looked at all of those

items, too, and if you see no comment, it doesn't mean that they haven't looked at them and are satisfied with what they see, but if you have any question, we'll be glad to have the Staff respond to it.

(sic)

MR. CHAMBLISS: Mr. Posta.

MR. POSTA: I would like to make a comment concerning, for instance, EMS activities. Many of our states are making applications to HSA for various EMS activities. Deadlines in certain areas have been April 15th.

We have other opportunities in area research for EMS that are going to be funded by another bureau and we have, from a Staff standpoint, made it clear that whatever we -- meaning RMP, DRMP -- will be funding will be double checked with the other agencies to avoid duplication in these type of efforts.

MRS. WYCKOFF: Is that what you mean when you list -- well, four EMS projects under concerns, that you're going to check them with these other to see if they should have applied somewhere else?

MR. POSTA: Right. And to see also if they're flagged whether or not the amounts of money requested in this application is, in essence, double that of what has been approved for the first six months of the year. So we do it both ways.

We keynote an expansion of an activity moneywise as

well as --

MRS. WYCKOFF: I see.

MR. VAN WINKLE: Continuations here aren't of concern in terms of the new legislation. Continuations are not of concern insofar as the new legislation. Only new start-ups.

MR. CHAMBLISS: All right. Are there other questions? If not, I think we should begin our review and our listing shows that the first regional medical program to be reviewed is Alabama.

The review is by Dr. Vaun and Mrs. Salazar, and the Staff person, who is already here at the head table, is Mr. Joe Jewell.

Will the first reviewer make his or her presentation?

ALABAMA REGIONAL MEDICAL PROGRAM

MRS. SALAZAR: Alabama has always led this parade --

MR. CHAMBLISS: Use the microphone.

MRS. SALAZAR: -- of the reviews, and I'm afraid I fell into that trap and I may get carried away, but I hope not.

The present funding of the Alabama RMP is $687,000 in the third year of a triennial status, with the year ending April 30th, for a total of four operational years.

The activities that were reported in the application are related to phase-out pursuits, rescinding of phase-out, reactivation, retooling, in response to the off-again/on-again syndrome that has bedeviled the regions all across the country this past year.

In view of this, the Alabama application, to me, is somewhat astounding from a number of standpoints.

First, after the phase-out orders in February of 1973 only two projects were approved for partial support and only four which were funded through contracts were continued beyond June 30, 1973.

Two: the Regional Advisory Council elected to remain intact -- the RAG is called RAC there -- it retained its working committees, and, indeed, throughout such troublesome times of adversity it grew in strength and wisdom, guiding and supporting the RMP efforts throughout the region. The RAC has met four times, reviewed proposals, set priorities, implemented new

by-laws, counseling and opening avenues of communication in their respective geographic areas of the region.

Vacancies that have occurred on the staff have been filled very promptly and attendance at all meetings has averaged better than 66 percent.

There is a nine-member executive board of the RAC. It has met six times, average attendance at 75 percent. The chairman is a member of the State Health -- the State Board of Health Department.

The third astounding feature of this application, to me, has to do with the ability of the region to seek and obtain local support for twelve out of sixteen of their continuation programs, twenty-one out of the thirty new proposals. Spoken or stated another way, in addition to the $2,648,000 they are requesting, $1,922,000 -- almost $2 million -- will be supplied by state, local, and other federal monies.

Or still another way, 73 percent of this application will generate other grant-related support, resulting in a total of $4,500,000 for the Alabama RMP -- is that correct, Joe?

MR. JEWELL: That's correct.

MRS. SALAZAR: The Review Committee and the EMS Committee have remained active, with the latter forming the nucleus of the State Advisory Committee to the Governor and the State Board of Health.

The membership of the RAC is adequately represented by providers and consumers from each of the 10 CHP B agencies and it includes the Director of the State CHP A Agency and a representative complement of health educators and providers, officials, and the like -- there's a mayor, too, as I recall.

The University of Alabama in the Birmingham Medical Center serves as the grantee and the present Executive Director of the Alabama RMP is on leave of absence from the university at 100 percent of time. Maximum resource support from the university is accorded the Regional Medical Program.

The present Director has had extensive experience with the Alabama RMP, having served on its first Regional Advisory Committee in 1967. She has been a member of various committees for about three years, has served as a part-time professional Associate Director. She has also been a member of the faculty of the School of Medicine for over 25 years, and for the past twelve years as Assistant and Associate Dean for Continuing Medical Education. She is active in medical affairs throughout the state.

The Deputy Director has been with the program since October 1970 and the Assistant Director for Operations has been employed by the Alabama RMP for seven years.

The position of Associate Director for Health Care Services, which will provide liaison with health providers throughout the region, is open. Recruitment is underway.

This unit is pursuing PSRO efforts and will provide an appropriate channel for emerging national health insurance information.

An Assistant Director for Multimedia Activities and an evaluator round out the professional staff and bring the total to its approximate prephase-out status.

There's a sense of optimism and enthusiasm that comes through in this application. It communicates a feeling of confidence in the competency and the wisdom and the motivation of the staff.

The region appears to me to be on target in meeting its goals and objectives as revised in 1971 to meet the changing national and local priorities.

It is quite apparent that enormous staff energy went into creating four of the initial six B Agencies in the state and it is still wielding a great influence on the emergence of the other four.

The Director of the CHP A Agency is a member of RAC and several members of the Area Health Councils are also RAC members. B Agency members frequently attend RAC meetings. There is excellent communication among all groups.

The endorsement of the Alabama Advisory Council for CHP A Agency is quite guarded, and there are some stated reservations concerning the duplication in sponsoring agencies, but for the most part these are fairly superficial.

As far back as 1967 the Alabama Regional Medical Program proposed in its first planning grant the development of six community-based health education centers to serve regional needs for health manpower education, service, and continuing education for all health professionals in the region. Eleven programs are now ongoing, covering all geographic areas of the state, and one is emerging in the resource-poor southeast section.

There is an exciting program that is entitled "Project HELP" which emerged from a tripartite agreement among University of Alabama, Birmingham-Auburn, and the State Health Department for health education of the public. It utilizes the services of the Agriculture Extension Service at Auburn University and county agents and councils in every county of the state. This program will receive future funding through state education funds.

The present application, as I said, generates a feeling of optimism in the reader. Cooperative arrangements have been achieved. Staff of both CHP A and Bs are actively involved in RMP affairs. Projects, both proposed and ongoing, are timely, relevant, and appear to be viable. They are particularly applicable to the region's health needs, but also in line with national emphases, such as PSRO and quality and cost controls of the health delivery system. These are all spoken to.

For the July submission the region is preparing additional projects in neonatology and one to develop a rural community health task force.

It is significant, I think, to note that the Regional Advisory Council incorporates in its committee structure the CHP B planning agencies. These areawide advisory bodies formulate policy and approve plans pertinent to health issues, not only project proposals from Alabama RMP but others requesting federal and state funds that affect their geographical areas.

From the very limited information to be gleaned from the report on the HRA-T4, I believe it's called, which is the Equal Employment Opportunity breakout and my previous knowledge of Alabama, it does appear to me that the Alabama Region has made progress in its Equal Employment Opportunity for minorities, but, I believe, still has a long way to go in achieving adequate representation of these minorities on their committees, particularly in the professional and clerical staff, as well as membership of planning groups and committees at the community level.

I'll cite you one example: the Regional Advisory Council membership is fifty-eight, only four of whom are blacks; the total professional staff is sixty-three, with eight blacks.

I will withhold my recommendations, Mr. Chairman,

until the other review.

MR. CHAMBLISS: Thank you.

I will now call upon the second reviewer, Dr. Vaun.

DR. VAUN: I'm not going to address attention extensively to the background because I think Mrs. Salazar has covered that well, and in a discussion that the two of us had initially, we agreed that she would address the background and I would talk somewhat about the projects.

I will start exactly opposite. I will address first and foremost my recommended level of funding, and then tell you how I arrived at that in analyzing the project.

I have recommended that their request of $2,648,439 be reduced to $2,028,389 -- this may be backwards, but this is my approach to this one with the background you've gotten on Alabama.

I think they've done a good job. I think the projects that they've submitted are congruent with their stated objectives, and I saw one thing that came glaringly through in the Alabama application, and that is that they gave me a feel for priorities, both from the CHP point of view and from the RMP point of view, and I hope this doesn't act to their detriment because it was really a splendid job and it's part of the way I arrived at the reduction.

Also I arrived at the reduction on the basis of some experience with like projects and observations about the

successes of like projects.

For the core operation of the Multimedia learning skills, the only reduction in core was $10,000 from that specific aspect of their project and not from project staff itself.

From the continuation projects -- and I really won't go into the details unless you want me to -- I have arrived at a level of funding reduction of $107,753. From their $565,005, I have come down to $447,252, and there is only one project that I really didn't feel warranted funding at all and that was the No. 82, which is entitled "Audio-Visual Assistance in Educating Hypertensives."

I don't know, I feel that there's so much of this around now that spending $7,000 on it in another area just doesn't seem like it was worth the effort.

The other $100,000 came from reduction of funding of several of the projects. As I say, I'd be delighted to submit my recommendations to Staff or go over them here, whichever you wish.

MR. VAN WINKLE: I think it will probably depend on what the final recommendation is.

DR. VAUN: Why don't I go through the rest of them?

MR. VAN WINKLE: All right.

DR. VAUN: From their new projects, they submitted $1,422,440; I would recommend a reduction of $492,297 to bring

their new application award to $930,143.

I was a little concerned again, although the projects are congruent with their stated objectives -- I think $11,000 for trophoblastic disease left me a little cool at this stage of our development; immunofluorescence for renal biopsies in the State of Alabama also left me a little concerned at this point; a rather sizeable sum of money for cervical cancer screening, I reduced substantially.

And then the PSRO which was $151,000, and a few odd dollars, I thought should be substantially reduced by $100,000. I just didn't feel this was appropriate.

So you have my recommendation in the light of Mrs. Salazar's background, and I wonder if that couldn't set the pattern. Don't you think it would be wasteful for both reviewers to spend a great deal of time presenting the background? Couldn't we arrive at some agreement and one person take one task and the other person take another task and, hopefully, come together on it?

MR. CHAMBLISS: Certainly I would await the judgment of this committee on that point. I think it will tend to expedite things.

MR. THOMPSON: So moved.

DR. WHITE: I take exception to it and object, in the sense that many of us have done work already -- admittedly scanty -- but it might be somewhat difficult for us to recast

ourselves in roles which we hadn't been expecting.

DR. VAUN: In the light of consultation amongst the two reviewers --

DR. WHITE: If time permits.

DR. VAUN: -- maybe one would have spent more time on one thing than the other, they could agree on a presentation.

DR. WHITE: If the two --

DR. SLATER: Mr. Chairman, I think it's quite easy to draw up background. Anybody can do that. But I think if there has been a fair amount of time spent in looking at the projects and considering them in the terms of the criteria you want, I think the individual reviewers have to go into this. There won't be that much duplication except as to background history. That seems redundant.

MR. CHAMBLISS: I seem to get a sense from the committee that you would prefer to hold to the original approach.

DR. WHITE: I think everybody has to play his own role, and if you don't like the way I do it, you can holler at me.

MRS. WYCKOFF: I tried to follow this thing, which is quite different --

MR. CHAMBLISS: You are seemingly suggesting that we have the clock before us and we can always call time.

All right. Can we get a motion, then?

DR. VAUN: Mrs. Salazar hasn't made her recommendation yet. She was going to withhold her recommendation.

MRS. SALAZAR: I defer to you as the principal reviewer.

DR. VAUN: Again, Bob, I'm new to this. Do I make the motion, or does somebody else?

MR. CHAMBLISS: You can make the motion if you choose, Doctor. You've already given us a level of funding that you have recommended and the rationale for that level. If you will put that in the form of a motion, the chair will entertain it.

DR. VAUN: I will move that the request of the Alabama Regional Medical Program be reduced from their requested amount of $2,648,439 to $2,028,389.

MR. CHAMBLISS: There's a motion on the floor that the recommended level of funding for the Alabama Regional Medical Program be placed at $2,020,389 --

DR. VAUN: $2,028,389.

MR. CHAMBLISS: $2,028,389.

Is there a second?

MR. TOOMEY: I second it.

MR. CHAMBLISS: It has properly been made and seconded.

Is there any discussion on the motion, please?

Dr. Miller.

DR. MILLER: To what extent do we need to pay attention to these motions for dollar levels in terms of the relative relationships of the various RMPs on this list? This motion places Alabama at a level that -- does it or does it not -- it exceeds the targeted available funds item, and without any consideration to the probability of what their statement was, an estimate of $1.1 million application to be submitted in July.

Are you going to count them out, almost surely, from much of anything on July 1st by this level at this time?

MR. VAN WINKLE: Dr. Miller, again, this is just an approval level. That's what's being recommended, an approval level. It does not necessarily mean that when it's actually funded that's what it's going to come out to be.

DR. MILLER: Could I ask, then, another question? What happens if this committee ends up with an approval level of $114 million this time; then you decide who gets what, right?

MR. VAN WINKLE: I suspect Council will --

MR. CHAMBLISS: Council will then make its recommendations based on the findings of this committee.

DR. WHITE: I think that's quite appropriate. The fact that someone here has seen fit to suggest that Alabama deserves more would be taken into consideration even though they may not get that amount -- they might get more in

proportion than some other region.

MR. CHAMBLISS: That's quite true.

DR. WHITE: It's simply a guideline.

DR. SLATER: I'm just wondering how to deal with this, too. I wondered how, as Dr. Vaun has, to deal with dollar amounts, and I guess what I'm searching for are guidelines. I've wondered whether or not we can't find the same problems that you have and indicate that our guidance is that within the framework of whatever cutbacks you have to make they shall not -- that they will have to redefine their distribution of funds to exclude the coverage rather than try and set a dollar level at this stage of the game.

In other words, I'd rather find fault with the thing, with the specific project, if we get into that degree of detailing, and then leave them with whatever funding level is ultimately going to be made possible, but within the guidelines that they're not to spend money on those particular aspects.

MR. CHAMBLISS: That is correct, Doctor.

DR. SLATER: That gets us away from dealing with odd dollars, and I don't know whether that satisfies your thinking.

DR. VAUN: I'm not sure I understand it.

DR. SLATER: Rather than assigning dollar cutbacks as you have, identify the concerns that you have and give guidance to the Staff and the recommendation to the Council

that within the framework of whatever dollar cutbacks -- they're asking for a hundred and thirty-six -- there probably is going to be some cutback, but in whatever framework, the money they receive shall not be spent on those particular projects. They have to define how they --

MR. CHAMBLISS: Well, I think he's simply been generous in giving us the dollar amounts and where, and we will -- the Staff will certainly take that into account as this goes through the review process.

MR. VAN WINKLE: And we would like Dr. Vaun's written figures -- details.

If you have them, we'd certainly appreciate them.

DR. VAUN: Maybe I'd better get clarification of that. Does that mean that if I submit the details that this is a mandatory translation to them where they cannot spend the funds?

That's what you were saying.

MR. CHAMBLISS: It does not. You have simply, based on your professional judgment, indicated those areas of concern, and they will be passed on through the review process and finally acted upon.

DR. VAUN: But it will be up to the region to decide finally?

MR. CHAMBLISS: Yes.

DR. VAUN: Fine.

DR. SLATER: Your indication of dollar amount is simply a reflection of your extent of concern.

DR. VAUN: Gut feeling.

MR. CHAMBLISS: Is there further discussion?

I'll call the question.

Those in favor of the motion, may I have the usual signal of voting?

(Ayes respond.)

MR. CHAMBLISS: And those opposed?

(No response.)

MR. CHAMBLISS: The motion, then, is carried, and we have finished our first review.

ARKANSAS REGIONAL MEDICAL PROGRAM

MR. CHAMBLISS: In our next region we have only one reviewer here at the moment. That region is Arkansas. And we will ask Dr. Carpenter if he will carry the entire load for that region.

Dr. Carpenter.

DR. CARPENTER: Thank you.

I don't have anything like the kind of background on this region that Mrs. Salazar did. My view is that the region has maintained the mechanism of the regional program adequately. The advisory committee remains intact; the review system remains intact; and that what we have is an application prepared by a reduced staff in an appropriately reasonable fashion, but in a depressive time which has forced them to, in the first place, be responsive to a large number of federal initiatives, some of which I don't believe were at their emotional heart.

Secondly, they had to respond, obviously, very rapidly and they, in the process, were forced to give up much of the matter of pressing for very detailed program objectives and there's essentially nothing in the application about evaluation either of the past program or of the -- and no suggested specific evaluation of most of the projects.

And, so, one has -- as I read the application, I have the feeling of a regional program which is a bit at sea;

has no real continuing thrust that can organize Arkansas in any significant way, though it does have enough thrust to contribute here and there in a kind of stopgap way, which I think most regions are going to have to be content with.

I believe that if I were in Arkansas I would spend the next year trying to document -- trying to develop a highly professional staff and document what its effect can be in terms of a detailed project plan.

I have in view the July submission. You can see from your computer printout here that the present funding level is $1.4 million; that -- as that somewhere, if we go through with their projected application, in July we'll be at a level -- which I'm having trouble reading -- of only 15 percent higher than what might be expected. On the other hand, it would be twice what they're now spending.

And I just don't believe that they've had an opportunity to organize a coherent program that's twice as large as the one they're presently involved in.

So my inclination would be to fund them at about the same level now and if the July application shows progress in terms of more detailed planning, then I think there's an opportunity to provide them with what will, I suspect, be a large enough amount of money for them for the next year.

So I'd recommend a funding level of $1,450,000.

MR. CHAMBLISS: At the current annualized level --

MR. POSTA: Excuse me, Doctor. That current annualized level projected over a year for Arkansas is $1,848,000, the first column.

DR. CARPENTER: My first column shows a million four.

MRS. WYCKOFF: So does mine.

DR. WHITE: Do does mine.

MR. POSTA: I guess it's the 17th edition.

MR. CHAMBLISS: We're working from the May 21st edition.

MR. POSTA: I'm sorry about that.

MR. CHAMBLISS: Thanks for that presentation.

I would like to ask if Mr. Posta will provide, in the absence of the second reviewer, the committee with any additional information that he chooses on Arkansas.

Mike?

MR. POSTA: I have been associated as Operations Officer to Arkansas since 1970. The Mid-Continent Operations Branch considered Arkansas to be one of the better programs in the Mid-Continent Operations Branch, primarily because of the coordinator who has just resigned in February.

I think that Dr. Carpenter's comments were quite relevant because Dr. Silverblatt has left the State of Arkansas. There is a question of leadership.

However, Mr. Roger Warner has been the evaluator -- the monitor and evaluation chief of that particular section --

and has done a good job in this regard and is serving in an acting capacity now.

The Search Committee is in process of selecting another coordinator. Mr. Warner is one candidate.

Seven of their top professional people have been on board for about seven years.

Now, last year when they came in -- meaning the last Council meeting in November of '73 -- the region responded to the five initiatives which DRMP had sent out to all of the RMPs; that is, "We want to do more in planning; we want to do more in quality care; we'd like to get something going in kidney, EMS, and hypertension."

Most of their application -- or their thrust during that period of time was in these five areas, and in this particular application they have what they call an "umbrella concept" within the core staff of ten particular areas where they have maintained those five original ones that we've mentioned and brought in position extenders more of a program force, unified health planning and new legislative concepts more in the area of hypertension and a couple of others that I can't recall.

Seventeen of the activities are new; seven are continuing.

I might refer you to your yellow sheet in the book. I think you all probably have that. It more or less reflects

what Dr. Carpenter just mentioned with reference to staff. They have currently on board 16.6 full-time people. They do propose 29.6 in order to do the job that they've set out.

I think there's been no problems whatsoever with the CHP A and B agencies. Arkansas was one of the first regions to have a complete blanketed state with eight CHP funded agencies.

The ARMP and the CHPs, along with what we call an "Estes" (phonetic) program, the Experimental Health Delivery System package, have been in operation in Arkansas for about four years. They have been funded with about $3.4 million of EMS activities from HSA.

In this particular application they do have an umbrella concept since the core staff did develop the EMS proposal that was approved by the then-HRA agency.

I could go on, but I think I'd better stop.

MRS. WYCKOFF: What do you mean by "an umbrella concept"? I see this in a number of these, and I wonder what does that consist of?

MR. POSTA: Well, within the total program staff budget, they have said, "We would like to administratively break up our entire program staff into ten areas," and they break out their budget accordingly, and those ten that I mentioned in hypertension -- they have one on arthritis that I didn't mention -- each of these people on staff would be

working in these particular activities.

Within the application, which does request $890,000 in this total program staff budget, you have about 13 percent of the over-all request in what we used to call a developmental component or, as they call it, contingency funds -- or as some of us would call water.

But I might say in all fairness to Arkansas that that is a mechanism of funding, and I dare say that all of the applications you see have certain developmental component funds listed.

MR. CHAMBLISS: All right.

I wonder, at the end of this presentation, if there's a motion for Arkansas, or are there further matters to be discussed? Are there further questions?

DR. WHITE: Their request is for a million eight, and that's only $400,000 more than they are getting at the present time.

DR. CARPENTER: Yes, and they're going to come in for some more in July.

I think it's very hard to set the funding level. For me, it was very difficult. If you try to go by -- you look at the projects and try to see which one would amount to something. I just don't have any confidence in anything from what they've described, and I, obviously, don't think we ought to make it impossible for them to start any projects. I think

their core needs to be protected, which I -- and, so, I sort of added a few projects to core.

DR. SLATER: The question I'm asking is whether you feel that they need to re-present what they have apparently done ineffectively for the July deadline so that they in fact are going to be coming back for the total amount that they were shooting for?

I'm not quite sure what the guidelines are that are associated with your suggestion for a continuation of funding at the present rate.

DR. CARPENTER: I was wondering about that, too.

DR. SLATER: Are they just to be given the money and then permitted to cut back where they see fit? How does this help improve their function?

I feel the same way you do; I'm at a loss as to how to react to them.

MR. VAN WINKLE: It would be too late, though, I think, to amend their July 1 proposal because their RAGs are meeting at the present time on that proposal -- I think most of them are, aren't they, Mike?

MR. POSTA: Yes. They expect about $800,000 new activities to be submitted in that July 1.

DR. CARPENTER: Let me comment on that. I think they do have RAG approval on these projects, and I -- it's obviously suggesting an enormous amount of work in an already

overburdened staff, but if I was to be convinced that they could spend more money effectively, I would need additional information about their -- the goals and the evaluation systems for the projects that they intend, and I would think it might be interesting to think whether we want to suggest that some region provide that kind of information in view of the difficulty of the rush (phonetic) of the projects.

MR. VAN WINKLE: All I was looking at is that Council will be meeting and we cannot relay any information back to them until after Council meets and their July 1 application would probably almost be in the mail to us by that time.

DR. CARPENTER: But presumably -- and this is what the key issue is -- in July if you are not going to do a project review and you are going to have only an application that describes projects --

MR. VAN WINKLE: It'll be a full-blown map --

DR. CARPENTER: Well, you see, that gives you --

MR. VAN WINKLE: It'll have to stand on its own.

DR. CARPENTER: Then that, standing on its own, could say, "Hey, look at all the progress we've made since last time in our project plan."

DR. WHITE: May I ask a question, Mr. Chambliss?

MR. CHAMBLISS: Dr. White.

DR. WHITE: This was a highly regarded region at one time; is that correct?

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DR. WHITE: May I ask a question, Mr. Chambliss?

MR. CHAMBLISS: Dr. White.

DR. WHITE: This was a highly regarded region at one time; is that correct?

MR. CHAMBLISS: It has been a highly regarded region.

DR. WHITE: The question now, Bob, is that there has been a change of leadership and some disassembling of things?

DR. CARPENTER: You know, it's hard to tell whether there's been a change in leadership or just, no matter how good your leadership is, this is an impossible situation, and it might be possible to say -- well, look at this -- I don't know if you can -- but as I look at the staff, they're being asked to do some very difficult things in terms of, you know, the details of the sickle cell project, for instance, and they're not able to do it, and I don't know whether that -- maybe in the past they would have gotten the expertise they need from their voluntary groups. For some reason or another, they don't seem to have it now.

I can't tell whether it's the leadership or the time element.

DR. SLATER: Your real concern here is not, I gather, on a project basis whereby you feel that one wants to cut back there, but some sense that the program isn't as strong, that the staff leadership isn't as strong, and it doesn't satisfy these criteria as well as you would like and, therefore, it should be generally kept at the present level?

DR. CARPENTER: Yes; I doubt that the staff can enforce high-quality projects of the type suggested.

DR. WHITE: That's a reasonable concern.

MR. POSTA: I feel very awkward in defending the region. I really do. I don't think that's my role as Branch Chief, on top of that.

DR. SLATER: May I speak to that? I think it's very important -- if the Staff have direct contact with the people there and they have a sense of history that we certainly can't pick up from one reading --

MR. POSTA: I assure you this is not the best application that Arkansas has ever submitted, and that's true because 15 days after they got instructions, the coordinator had long departed.

However, they do have what I consider a good, small staff. Arkansas has never had a big staff. We're talking about a state that's forty-ninth in the country as far as average income is concerned. They have limited providers.

I think that -- just as an example in this particular application, for the amount of other sources of support which is included in your conglomerate budget, they have state funds, local funds, and other federal support of $415,000; mainly through the RMP, the EMS application was approved and plans put into the CHP A agencies were likewise approved.

They, along with the VA, were instrumental in drafting the proposal whereby Arkansas has a state Estes program. These folks have been working closely together. The University personnel is involved and definitely involved with these

particular projects that are in the application, including the particular function, such as quality care. They have the nucleus of the program in the form of a contract now going on which has set the stage for the other eleven bigger or larger hospitals in the state to follow that pattern.

The hypertension program which was a thrust from us, as of last year they have carried the ball with that and have hypertensive programs going on in each of the states. (sic)

They have drastically improved as far as the minority concerns their Council and review committees have had in the past.

Their turnover of the Regional Advisory Group is almost nil, and I feel that the ARMP, the Arkansas RMP, is much of a stronger agency when you look around at the CHP and its leadership there and the Estes program -- in particular, in the EMS portion that is being funded under Estes. They're looking to ARMP for that leadership and guidance to carry that program in the State of Arkansas.

Now, that's not to say how much money they've come in and gotten for cancer -- or have received from the cancer program or the heart program or others.

Now, I'm responding only because of what was said earlier with the previous region, and you're coming to a decision here. I agree that the token figure of 140 percent is something to shoot for after the May 1 application is

received, and I really don't think your recommendation is that far off, but I felt that I needed to defend this region just a little bit more, because we feel, at least at this level, that they haven't done that bad a job.

MR. THOMPSON: You see, this comment is now pushing us down to looking at specific projects. This is what worries me.

MRS. WYCKOFF: And we can't do it. There's not enough information for us to do it that way.

MR. CHAMBLISS: We do not propose to look at specific projects, but simply the program and the objectives of the program at this particular state.

I would say, based on the presentation from the presenter and Mr. Posta -- I would ask -- I perceive the recommendation that Dr. Carpenter has made with regard to the level of funding. I have heard a number of items of rationale as to why he arrives at that point, and I'm wondering if I could get a motion on the floor for your recommendation, Dr. Carpenter.

DR. CARPENTER: Well, in view of some of the discussion, let me move that we approve $1.5 million for Arkansas.

MR. CHAMBLISS: It has been moved and seconded --

MR. VAN WINKLE: No second yet.

MR. CHAMBLISS: It has been moved that the level of a million five be recommended for Arkansas.

Is there a second to the motion?

DR. VAUN: Second it.

MR. CHAMBLISS: It has been seconded by Dr. Vaun.

Is there discussion on the motion?

DR. WHITE: I can sympathize with Bob in trying to come up with a figure that's more than he wanted but less than they asked for, but I don't know how we come to that rationally. Is there some other alternative to this? Is there some way of saying they deserve to be considered for an increase in monies beyond that which they're currently getting? We would not like to see them get more than the -- what do they call it? -- targeted funds, and preferably less.

MR. THOMPSON: They didn't ask for the target -- they only asked for 80 percent of the target.

DR. CARPENTER: But they'll be up to 115 percent by the time it's all over.

MRS. WYCKOFF: They want $782,000 new. That's a lot of new.

DR. SLATER: May I ask a question on this? On the next round that we're going to be sitting on, are the criteria going to be different than this round, or are we really going to be looking at projects in the old way?

MR. CHAMBLISS: The criteria will be the same.

DR. McPHEDRAN: We will not be looking at projects?

MR. CHAMBLISS: We will just engage in the project

review.

DR. SLATER: Since this is on the floor, and having known Arkansas in the past, I have to give the benefit of the doubt to the staff in Arkansas under these situations. I think they've been through the mill and if there is a proposal that comes in that looks as if they're a little bit at sea, I don't know what else to do except say, "That's the way our country operates right now," and I'm inclined to move the money out of here so they can stay alive in their present state of health or at least their desired state of health, and I'd like to speak in favor of giving them what they ask for.

MR. CHAMBLISS: Any further discussion here?

DR. CARPENTER: I have obviously thought of that, too, as an approach we can take. I have in the back of my mind, I guess, something which is going to surface repeatedly, and it might as well surface now.

I think that local planning efforts have been slipshod and we're now moving toward a time when we're going to try to redo the mechanism for local planning, and I believe that one of the messages that has to get back, one of the matters which deserves our consideration, is that you just can't reward low quality planning, and I don't see that -- you know, for instance, as this region begins to choose who its leaders will be in the health planning business, I think they need to choose very talented people, and I'm not anxious to

lead them astray.

MR. CHAMBLISS: Is there any further discussion on the motion?

MRS. SALAZAR: In an attempt to sort of meet halfway between these two points of view, I would hope that the message that goes back to this region is not punitive in any way. Certainly the staff must be having a pretty hard time with their strong leadership having disintegrated, and I think they need to be encouraged at this time rather than punished.

MRS. WYCKOFF: What about the kidney and the EMS and that sort of thing there? Did you discount those as things that should be supplied from other sources?

DR. CARPENTER: Well, frankly, I didn't. I don't -- it seems to me that the health planning leadership in an area might well invest some monies in assisting that area to meet very specific goals of categorical federal programs, so with that philosophy, then, I didn't get -- and from what I heard about our guidelines, I gathered that we could permit some of this. I didn't really -- I can't say I discounted those.

MRS. WYCKOFF: What about this arthritis money?

MR. THOMPSON: That's separate. There's a special group of people out there (indicating).

DR. CARPENTER: Is that a core -- I think that's part of their core activity to assist the region to develop an application for arthritis funds, and develop the regional

system in support of that application.

DR. SLATER: I wonder if there's some other alternatives available here. We've in the past been able to send messages back. For instance, staff guidance. We've been able to lay out visits if we're concerned -- site visits if we're concerned about providing allocates (phonetic) of money. We have been able to pass things on -- for instance, hold it over until the next round subject to review by an elite group.

Are we under sufficient pressure here to respond to this one-time allocation? It's a survival matter, and we just use our best judgment here?

MR. CHAMBLISS: Certainly we're called upon to use our best judgment, but the region will get advice as this whole round of review terminates, and the concerns being expressed here now will be incorporated into the advice letter going to the region.

DR. CARPENTER: I have a question here. When their July application comes in, will it be a request for a certain dollar amount of supplemental funds or will it be a request for a new funding level?

MR. CHAMBLISS: It will be for both. You will note in your column "July 1 Estimate" that the region anticipates that it will request a sum approximating $800,000.

MR. THOMPSON: Additionally.

MR. CHAMBLISS: That's simply a request. That does

not mean that that sum will be awarded, because you know the over-all limitations that we have on total funding. All of this will be fitted into the amount of the available dollars that we have once the final decisions are made by the court.

DR. MILLER: That $800,000 is going to be for a series of projects, new projects, right?

MR. CHAMBLISS: Right.

DR. MILLER: On what basis are we going to make a decision about awarding Arkansas $800,000 for a bundle of new projects?

MR. CHAMBLISS: That is only an anticipated figure. That is what --

DR. MILLER: I don't care whether it's $100 or --

DR. WHITE: It's going to be on the same amount of concrete evidence that we have today.

MRS. WYCKOFF: Exactly.

DR. SLATER: It seems to me that we're going through a problem whereby a traditional review committee is having a hard time learning how to operate like a council, and this is in fact what we're being asked to do. We're being given a list of projects we are not able to technically analyze, but we're asked to look at their conherence within the framework of the history of the program and the objectives of RMP. And it seems to me that's what the Council used to do, and it may well be that in the future, whatever comes out of the

legislation, some other kind of system will have to be put together, but I would guess that we're not going to be able to operate comfortably like a traditional review committee and we are having to look much more at policy and staff security and so on.

MR. CHAMBLISS: We share your discomfiture.

DR. SLATER: I don't know how else to make these decisions.

MR. CHAMBLISS: Dr. Vaun?

DR. VAUN: As the seconder of the motion, I'd like to reaffirm my second of the motion on the basis of the discussion I've just heard. I don't see that this is in any way a hindrance to the group.

I think it would be dangerous to give them more money than the leadership can use at this point, and they have an opportunity to come back again, and if there's going to be a total and complete presentation, if they get a few messages on this round, there's no reason why the discussion can't be different on the next.

I don't think this is a punishment or a harm to them. I think it's a rational decision on the basis of their leadership at this point.

MRS. WYCKOFF: Call for the question.

MR. CHAMBLISS: I would simply ask that those in favor of the motion let it be known by the usual sign.

(Ayes respond.)

MR. CHAMBLISS: Those opposed?

(Opposed respond.)

MR. CHAMBLISS: There are two opposed, Dr. Slater and Mr. Thompson.

The motion is carried.

Did you have further --

MR. POSTA: I wanted to know what is the official motion?

MR. CHAMBLISS: The official motion is that it is recommended that the level of funding for the Arkansas Regional Medical Program be placed at $1,500,000, with the concerns expressed by the members of the Review Committee going to the region.

DR. CARPENTER: Particularly that they support that core.

MR. CHAMBLISS: Shall we move then to our next region, Bi-State?

BI-STATE REGIONAL MEDICAL PROGRAM

MR. CHAMBLISS: The reviewers are Mr. Toomey and Dr. McPhedran, and Mr. Frank Zizlavsky will be the Staff person here to give the necessary support.

Mr. Toomey.

MR. TOOMEY: I utilized the review --

THE REPORTER: I'm sorry, sir, I can't hear you.

MR. TOOMEY: -- for the basis of this discussion.

In reading the application I think the first thing that struck me -- was the microphone -- was the fact that the Regional Advisory Group disbanded and turned over the responsibility for the program to a 15-man executive committee. That 15-man executive committee has functioned. However, as time went on, very recently the program coordinator himself, Dr. Stoneman, resigned, and in the material that was sent I had, in reading it, a tremendous feeling of frustration on the part of the material that was written.

All of the program staff, however, seemed in terms of their experience to be an experienced staff. I could look the figures up, but it seems to me at the present time they have somewhere in the neighborhood of eleven program staff; whereas, their organizational program would call for about nineteen.

In looking at the past performance and the accomplishment of the Bi-State RMP, it seemed initially in tune

with the heart disease, cancer, and stroke programs, although it was affiliated with both Washington University and St. Louis University and these two universities were the granting agencies.

Later in the program the major thrust was in emergency medical services.

In looking at the even more recent programs, they have not substantially addressed the problems of accessibility and availability of care with the exception of the emergency medical services, nor have they addressed themselves to the needs of the minority groups, nor to health delivery systems. In fact, they are in a very, very particularly difficult kind of situation because they're attempting to provide a program for the rural Southern Illinois and the urban St. Louis area, and I'm sure that the conflicts in terms of the needs of both these areas are expressed in terms of the variety of programs.

At the present time they are requesting EMS continuation grants, assistance to local planning, including some health manpower planning, quality assurance, manpower recruitment for the disadvantaged, and projects related to cancer and kidney disease.

Now, with the exception of the EMS, the projects that they propose do not in fact fall within a document which was in this proposal which was called, "The Health Needs of Bi-State RMP Region as Identified by Joint RMP and CHP

Planning Conference."

In February RMP and CHP met together and they selected three or four areas that they felt were necessary for the development of programs within the Bi-State area, a need for improvement of emergency medical services -- and that one, of course, they have worked on.

Secondly, need to improve accessibility to quality health care.

And the third was need to improve the availability of trained health manpower for the entire region.

And the fourth was need to coordinate health care delivery planning.

Skipping the feasibility for a moment, as far as the funding is concerned my comment here would be that the projects probably could be accomplished, but they do not seem to be compatible with the needs expressed in the joint RMP-CHP memo.

In terms of their relationship with comprehensive health planning, despite the memo that is in the proposal from RMP, my feeling in reading the comments from CHP -- well, I noted them as being polite but restrained, and very restrained. I think I read into it, certainly, that there was not a tremendously happy relationship with that relationship.

As for the funding -- you can read this with me -- I did not have it and I am interested in seeing it -- but at the present time the present level of spending annualized is

$870,000 -- almost $871,000. The targeted available funds, $1,256,000. The May 1 request which I am presently discussing is $1,129,000, but there is a July 1 estimate of $410,000 which places them at a figure in excess of the targeted available.

On the basis of my own review of this, reading this material, frankly -- and the feeling that I got from reading the projects and reading the comments and relationships with CHP, it would seem to me to be the unsuitability of the projects in terms of the direction in which I felt RMP was attempting to move itself.

I recommended only $800,000 in funding for this current recommendation.

MR. CHAMBLISS: Thank you.

We will now call upon our second reviewer, Dr. McPhedran.

DR. McPHEDRAN: Mr. Toomey and I both were on what I guess was the latest site visit, formal site visit, to Bi-State, and the program -- this regional medical program we thought at that time had had a lot of difficulties with organization and there was some delay, as I recall, in their getting triennial approval, and I think that was true of several other regional medical programs, but we were always concerned about leadership in this program.

They had had a great many problems with their

relationships with the medical schools and it was perhaps a blessing in disguise when the medical schools withdrew, but I don't really think that the program leadership appears to have entirely gotten -- once they got rid of what was really an incubus, that is, their relationships with the medical schools, I don't really think that they got any sort of coherent direction of their own.

And I'm surprised to see that the Regional Advisory Group seems to have relinquished its responsibility -- I agree with Mr. Toomey's assessment of that. I thought that the Regional Advisory Group itself was capable of providing stronger leadership than that.

In reviewing the projects, I looked at the two new ones sort of as a touchstone for what direction they wanted to take rather than, I thought, technically reviewing them.

I think that the RAG or what was left of the RAG when they met in February with CHP, I think that they felt that the rug was pulled out from under them when no new EMS projects could be begun and what they have actually requested in the way of new projects are perhaps a dim reflection of what they would like to have.

Of those two projects, though, one of them does address minority recruitment and it has been such an important lack in this program before that I think note should be made of the fact that they seem to have come up with a project that,

in the bare bones that are given here, looks reasonable.

The other new project, which is a study of what's happened to manpower trained in a consortium that they partly sponsored, is something which I find myself not much in sympathy. It seems to me that the study -- I don't see why it requires this separate funding.

So that, rather than use this as a part of technical project review, I think that I would like to present it as a kind of example of what I think are the difficulties that they're having in getting a program direction.

Similar things could be said about some of the continuation projects, but I was interested to note that the requests for quality assurance -- two of the requests for quality assurance relate to programs in out-patient practices, and I don't know whether that comes under the same kind of scrutiny as PSRO in hospitals -- Mr. Thompson shakes his head and says not -- because this is --

MR. THOMPSON: Right now legislation restricts it.

DR. McPHEDRAN: The restriction relates only to hospital-based activity, hospital and nursing home activities. Well, that's what I thought, but I wanted to be sure about that.

MR. THOMPSON: With the option, and you know damn well they ain't going in that direction.

DR. McPHEDRAN: But the purpose of these projects

for continuing support seems to me laudable, although I must say I didn't like what I saw as a technical matter in one of them. Nevertheless, I felt that their purposes were laudable.

I don't disagree with Mr. Toomey's funding level because I find such difficulty in coming up with one of my own. It's very hard to know. I think that, for example, the request for core staff, which is about $550,000, as I recall, for direct and indirect costs -- I assume that that's based on an expectation that they would have their eight plus five staff, a total of thirteen staff. Since that is at least half of what we -- five-eighths of what we would be talking about, I don't really know whether they can get along and do anything worthwhile without increasing the core staff, but I'm reluctant to accede to the request to increase it by that amount because I'm not really sure that they can use the staffing.

And Mr. Zizlavsky has been there recently, I think, on technical matters, and maybe he could address himself to that question.

MR. CHAMBLISS: Mr. Zee, will you fill in there?

MR. ZIZLAVSKY: There's about three or four areas I'd like to comment on, and I might as well comment on the program staff area right now.

That $550,000 figure for program staff is really gobbled up by indirect costs from these two universities. That's Point 1.

These five additional staff -- four of these staff are secretaries. They may be a little heavy in the secretarial area -- in the secretarial-clerical area by having seven secretaries for eight or nine professionals, so that may be a little too much.

The basic other program staff request is for a deputy coordinator and what they would call a programs operation -- regional outreach person. I think these two are legitimate requests.

A comment about the RAG responsibility and the decrease from 75 members down to 15 members. Going back into our history, not to drag this out, but May 1973 was a "go/no go" type of month. Everybody was down. The results from RMPS came out in terms of recommendation for funding on the phase-out plans. Bi-State's program -- final recommendations for phase-out on this program were pretty skimpy.

By June 30th they probably had five or six total staff on board. I'm not asking for any sympathy from the reviewers, but it was at this time in May that the Regional Advisory Group thought RMP was really going under, and this was the main area where they delegated their responsibility to the executive committee.

Subsequently they have come back and they are starting to build right now in terms of increasing the RAG. They had not made that decision yet because of the future problem

in terms of health resource planning. Why put types of people on Regional Advisory Groups which might not be the future type of people?

Mr. Toomey is correct that in several areas they have not addressed accessibility and availability. They have improved in the area of minority representation. During the phase-in period they have been able to hire one minority person on program staff and they're leaning heavily on this person to really get into the St. Louis area, which really in the past they have not done an effective job.

I would have to go along with the recommendation for $800,000 considering the factor that the July request is a $410,000 request. They are under review for 31 projects presently, which there isn't any information in this application.

My best estimates in talking to the program involve that they decrease the 31 projects down to 24 projects, and this is the $410,000 estimate coming up.

MR. TOOMEY: May I ask Zee a question?

Was my feeling right about the relationship between the CHP agencies and the RMP agencies? I got a feeling of some conflict.

MR. ZIZLAVSKY: The only area of conflict is dealing in the area of EMS. There was a subtle arrangement that when the EMS activities started up and the eight contracts were

awarded from HSMA (phonetic) at the time, the St. Louis area came in with a rather large contract. Simultaneously it was submitted to RMP and we recommended a $200,000 recommendation and they finally received $100,000, and they were one leg up on EMS planning for the St. Louis surrounding area.

This present project director, Dr. Wheeler, also has almost a million dollar project request in to the Kansas City Regional Office, which is their respective regional office, for new EMS legislation. We had a phone call yesterday from the regional office, and so we're on top of this situation.

In getting very specific, the ARCH, which is the Alliance for Regional Comprehensive Planning, in the St. Louis area is an eight-county CHP B agency, they wanted to get into the area of EMS planning, but the RMP was funded in this area for planning. The National Advisory Council limited their activities to planning and training and there was an agreement between the RMP and the CHP that the RMP do the work.

The conflict now comes out in this application because no signals were given from the Kansas City Regional Office. RMP can no longer get into this activity. These are new monies.

I think you're going to see that this is just a symptom of what's happening nationally. Hopefully, we'll keep our -- we're on top of it, though.

MR. CHAMBLISS: Dr. Vaun.

DR. VAUN: Could you elaborate just a bit on this large amount of money that's being gobbled up indirectly by the two universities -- just a little bit?

MR. ZIZLAVSKY: Well, maybe "gobbled up" was too strong.

MR. THOMPSON: Ripped off?

MR. ZIZLAVSKY: Pardon?

DR. VAUN: "Ripped off," he said.

MR. ZIZLAVSKY: As you casually look at the indirect costs rates established for St. Louis and Washington University, you have something like 80 percent rate for Washington University and 68 percent for St. Louis University.

I attended their March -- no, their April 1974 Regional Advisory Group meeting when they were discussing their money problems, and everybody was concerned how to get more money, and I suggested to them that one of the areas they might consider was to reduce their indirect costs rates as some of the Regional Medical Programs have done, and --

MRS. WYCKOFF: They haven't done it nationally, then, by putting a ceiling; it's all negotiated?

MR. ZIZLAVSKY: It's all negotiated, yeah. Larry Pullen may want to comment on the technicalities of how these-- I don't know --

MR. CHAMBLISS: Well, suffice it to say that it is a

negotiated rate and there would be very little that we could do at this point. I simply bring that to the attention of the committee.

MR. THOMPSON: Most universities have off-campus rates --

MR. CHAMBLISS: Mr. Thompson makes the point that most universities have off-campus rates. That's nowhere near this. Some do, yes -- most do, but in the case of this rate, it has been negotiated and we would be at a loss to make a change there.

The chair would entertain a motion on Bi-State.

MR. TOOMEY: I'll so move.

DR. McPHEDRAN: I second Mr. Toomey's motion -- I assume it was the --

MR. CHAMBLISS: It has been moved and seconded that the recommended level for Bi-State be $800,000.

Is there discussion?

DR. WHITE: Could I ask -- this is the ceiling now, $800,000. Suppose the staff comes to looking at this whole thing and they devise some kind of formula whereby everybody gets X percent of what they ask for or what we said they should get? These people may end up with substantially less money than they have this year. Is this what you want?

MRS. WYCKOFF: What does this do to the continuation projects that are listed at $500,000 there? Are some of

those capable of being terminated or phased out?

MR. ZIZLAVSKY: There's a total of 17 projects. Fifteen are continuations. There are only two new projects.

MRS. WYCKOFF: What about the fifteen? Are most of those --

MR. ZIZLAVSKY: I'm trying to get -- in terms of being continually supported by outside sources of funding?

MRS. WYCKOFF: I wondered if they could be shifted over to something else quickly, you know, if they're dependent on continuations --

MR. VAN WINKLE: Your staff and continuations come up to over a million.

DR. McPHEDRAN: I'd like to say something that, in a way, is in response to what Dr. White said. We had an informal conversation earlier in which we were talking about what happens when this $115 million is to be distributed on relatively short notice and after so much phase-out has occurred, and of the two possibilities -- one, that it might not all be used and, two, that it might all be used but used in a way that would not necessarily reflect favorably on DRMP or the Regional Medical Programs -- I guess that I would really rather see the former.

I think I'd rather have us be in that position, so that's why, I guess, I favor these low funding levels, because I don't really feel that this program, this Bi-State Regional

Medical Program, can usefully employ a whole lot of money, and I think I'd rather see some of it just not distributed. I can hardly imagine that that will happen, but if I had to choose, I think that's the way I'd choose to do it, so that's why I think I support Mr. Toomey.

MR. TOOMEY: I'm like Dr. Slater. It's a little bit difficult to be precise and to be totally objective about these things.

As Dr. McPhedran said, we visited there -- I guess it was two years ago -- and in the course of two years there's much that slips your mind, but I'm certainly reminded of the fact that Southern Illinois, in the rural sections, has some very, very great needs and also great opportunities for some good planning because Southern Illinois University is tremendously interested in what goes on in those rural communities.

This is covered by Bi-State RMP, and there was rather an impassioned -- I guess in a sense an impassioned discussion by one of the Southern Illinois representatives at the meeting that we attended, and I don't see anything really that relates to the rural needs of Southern Illinois.

And then there is little or no doubt that in both East St. Louis and St. Louis that there are major problems of planning and health delivery, concerns related to accessibility, availability, sponsorship of programs, and I had the feeling both at that time and now in this presentation that the

staff was just not focused in to see what could be done, even to study and to analyze and review and work toward those areas, and it may be, having been there and having undergone the kind of disillusionment, in a sense, that you would feel -- and it's within this very subjective kind of feeling that I made the motion.

A VOICE: Call for the question.

MR. CHAMBLISS: I heard that the question has been called.

Is there further discussion?

MRS. WYCKOFF: This means it's less than they're getting now; is that correct?

MR. CHAMBLISS: The recommendation is that Bi-State be funded at the level of $800,000.

DR. SLATER: May I ask a question? Would you recommend that they be phased out? I'm wondering why we're setting $800,000. What we're saying is --

MR. TOOMEY: I don't think they ought to be phased out. I think that Bi-State as an organization should be divided into at least two parts. It would mean the construction of another unit, but I think that, as far as I'm concerned, this would make sense.

DR. SLATER: Then I think some kind of rationale for this that's constructive in the sense -- in the sense that you just put it -- if you go back with a budget cut superimposed

on top of a phased-out program that's already existing --

MR. CHAMBLISS: Staff will take note of the rationale and the concerns that you've expressed here.

I'll call the question, then. Those in favor, let it be known by the usual sign.

(Ayes respond.)

MR. CHAMBLISS: And those opposed?

(No response.)

MR. CHAMBLISS: Then the motion is carried.

I would simply ask -- we're reaching the dinner hour -- the lunch hour, rather -- I will ask before we break for lunch that those reviewers take just a moment to complete their review sheets, and we'd appreciate it.

And then I'd like to get a consensus from the committee as to when we should return. It is now ten of 1:00. I would say -- I would suggest if we could be back by 1:30, it would give this committee a chance to move forward.

I would simply let you know that we have accomplished one fourth of today's workload, and I would certainly suggest that you return so that we may complete the twelve regions that we've set aside for this day's work.

I would now say that lunch is now being served.

(Whereupon, at 12:50 p. m., the committee recessed, to resume at 1:30 p. m. of the same day.)

AFTERNOON SESSION 1:35 P.M.

MR. CHAMBLISS: If we could reconvene the Panel, I would like to put you on notice about some adjustments that we would like to make.

The first adjustment that we would call to your attention is that we have a new Recorder; Miss McClure is no longer with us and Mr. Dillingham is now our official Recorder.

Secondly, I would have you note that Doctor White has to be away from the Review Committee for an hour or so, and he has asked if we would move Georgia up just below Colorado-Wyoming, and that would give him an opportunity to go away and return later on in the afternoon. His co-reviewer has been notified.

I would like you to note also that we would like to move Wisconsin up in the place of Iowa, and hopefully we would be able to get Wisconsin today.

MR. THOMPSON: We don't have to stop, do we, in case we go beyond that target?

MR. CHAMBLISS: Oh, no; we can go as long as the Committee wishes, and I would encourage the Committee to have a late dinner if it so wishes.

DOCTOR SLATER: Do you think there is any possibility of finishing by later tomorrow afternoon?

MR. CHAMBLISS: We would endeavor to do so, and

with your help, we can.

I have a sense of where the Committee would like to go in terms of the timeframe and the workload. Are there other suggestions here?

MR. TOOMEY: Let's finish by tomorrow afternoon.

DOCTOR SLATER: That means getting the whole group together again by what -- 3:30?

MR. CHAMBLISS: I would like you to note that on Friday the two panels must reassemble.

DOCTOR SLATER: We are suggesting that for 3:30 tomorrow afternoon.

MR. CHABMLISS: We will have to see how the other panel is moving.

MR. THOMPSON: I can't be here Friday myself.

MR. CHAMBLISS: There has to be some coalescence of the various recommendations from the two panels, some coordination.

I would then call next for review the application of Colorado-Wyoming, and please note that Doctor White and Mrs. Wyckoff are the reviewers, and Miss Mary Murphy is the staff person.

Doctor White?

REGIONAL MEDICAL PROGRAM REVIEW

COLORADO-WYOMING

DOCTOR WHITE: As a preamble, I might mention that I am a lumper rather than a sorter, so I have looked at this in a rather global manner, rather than looking at projects.

I have the fortunate perspective of having made two site visits to Colorado-Wyoming in the past, and know something about it from personal experience.

I know Doctor Nicholas, who is the present coordinator of the Region. Tom was Chairman of the RAG for a couple of years, and then decided to take on the job of coordinating the program, and has done a commendable and worthy job.

Tom is a fellow who has been known around the Region for many years; in addition to his talents as a physician, he runs a ski-resort, a small private plane enterprise, because he practiced in Buffalo, Wyoming, and this required commuting by airplane in order to go anywhere.

So he is well-regarded, well-known, and ambitious, an energetic, relatively young man. He is active in the area, he is knowledgeable in the area and he is accepted in the area.

The staff, according to the proposal presented to us at the present time, has been retained, in large part. This Region remained optimistic, even through the period of trial and tribulation. Most of them remained on the staff; some of

WD-4

the names I recognize as having been there two or more years ago, and they are planning to add even one or two more to the staff to deal with this Health Resources Planning and Development, which seems to be the direction that they're told to go in conjunction with the Hill-Burton, CHP and others.

There is an adequate description in the application as presented, in which they describe the staff and the individual qualifications, and so far as I can tell, all seem to have the appropriate backgrounds, experiences and degrees. And I believe there has been Washington staff visits out there to assure that they have good management practices, and follow the guidelines that have been laid down.

The Regional Advisory Group has continued to be very active. It has completed, in this period of time, a review of all past funded projects, since 1968. Now, I've forgotten exactly how many of these projects there were altogether; I think more than 20 -- obviously more than 20.

18 of these are now self-sufficient, either being run by someone else or generating their own support, and six they feel will become self-sufficient when RMP expires.

The Regional Advisory Group has been expanded in numbers to deal with the geographic dispersion that is required in Colorad-Wyoming, in the sense that they can't get together easily, and also expanded to deal with certain new objectives. They have brought on talents which have to do with

HD-5

developing health resources and things of that sort.

They have continued to meet quaterly, as scheduled, and almost every individual member of the Regional Advisory Group is said to have participated in other committee functions, and to have made site visits, particularly in reference to this review of past projects.

It has reconsidered its goals, and has determined that the Regional Medical Program of Colorado-Wyoming is a viable one and will continue, in some form or another, even after funding subsides.

Its past performance, I think, is excellent, as witnessed by the fact that a significant number of its projects undertaken in the past are now self-sufficient and continuing. It has become an accepted and utilized resource; for example, it was designated by the Governor of the State to be that agency which would undertake planning for the Emergency Medical Services for the State of Colorado, and I think in Wyoming as well. And it will continue to function in this regard.

It has -- in our past visits, and both Mrs. Wyckoff and myself have been there -- I think we have recognized that their goals and objectives are consonant with those laid down by the Office here in Washington.

So far as I can tell, without looking at the projects in great detail, and basing my judgment on the fact that I

trust these people, I believe that what they are proposing to do this year will indeed be feasible within a year's time, in large part, and will have some hope of continuing under someone else's aegis at the termination of the support from Washington.

The activities proposed consist of seven activities addressed to the problems of availability, accessability of care; one addresses the need for more primary care types of individuals, and it is worthy of note that the Regional Medical Program in both Wyoming and Colorado was instrumental in getting legislation passed to permit utilization of these other professionals in rendering health care.

It has two new and one old objective, which served the regionalizationalization concept; this is important to this area because this is such a widespread geographic area, with dispersed population centers and very sparse population centers as well.

The only -- there were some proposals which I was not sure were appropriate under the material that we received from Washington. They are proposing a Bone Pathology Center, which I assume has to do with cancer in large part, and it seems to me I read something -- and Mike, you can correct me on this -- that some of these things were to be taken over by the National Cancer Institute, were they not, in some way or another?

WHD-7

It also wants to continue a Cancer Registry, which I think is more appropriately under the support of the Cancer Institute, and radiation time-sharing studies.

Even in the past I had some concern that they were emphasizing pediatric dialysis centers inordinately at the expense of certain other activities, and they are proposing even now to establish a pediatric nephrology center, to the tune of $83,510.

I don't believe their EMS activities conflict with the policy, in the sense that they are continuations, more or less, of what was going on in the past, and they will not be operational programs, but mainly development and planning.

So far as I can tell from the letters of endorsement, their relationships with Comprehensive Health Planning are amicable, and indeed, they dovetail very closely in some of the more remote areas; Grand Junction is one which comes to mind, for example.

The letters were generally supportive, neither vindictive nor overly filled with praise, but I think they indicate that there is a good relationship between Comprehensive Health Planning and the Regional Medical Program and that in all probability, there will be joint development of programs for these health resources facilities.

The other comment I would have is that the whole tenor of the application is one of reasonable optimism -- not

JHD-8

that Regional Medical Programs in its present form will be continued, ad infinitum, but that they have at least established that they have a viable role in the State of Colorado and that the State Health Department, the schools -- whatever other funding agencies come along, will utilize this talent that is already there and not let it disband and disperse and be lost.

I did not come to any firm figure in terms of recommending support. I have a certain uneasy feeling of disquietude in the sense that I find it difficult to really understand how any Regional, no matter how good it is, can ask for a highly substantial increase in its sums, and in such short period of time adequately reviewed their pertinence to their needs.

Now, I can't say that for sure, because I did not look at each of their projects in great detail, but just on that general principle, I would think that, and it would be my recommendation, that Colorado-Wyoming be considered for the targeted amount, and I say that in terms of what I just discussed and in terms of knowing that they are going to be coming in in July asking for another quarter-million dollars and that in all probability they are not going to get what they asked for in any event.

That would be my recommendation, that they be allowed up to $1,587,644, which is the targeted available funds

seen, with the option that they can apply for more in July, which they expressed an intent to do.

MR. CHAMBLISS: Thanks for your recommendation, Doctor White.

We will now call upon Mrs. Wyckoff.

MRS. WYCKOFF: I made a very long report, and Doctor White has said most of it, so I don't want to take up more of your time with this.

I feel that the characteristics of this Region, which is a very far-flung one, which -- it is the same distance from St. Louis to Washington as it is across this Region -- that is quite a large Region, and their interest in regionalization and in reaching out, and in their use of things such as the Emergency Medical Services, and their attempts to strengthen the services to this extremely rural area, are very worthwhile and very well-designed.

DOCTOR WHITE: Doctor Nicholas is a real mountain-man, who understands the mountain psychology.

MR. CHAMBLISS: He is from Buffalo.

MRS. WHYCKOFF: He knows how to work with this Board, and he has kept their enthuasiasm up. I think they are very fortunate in getting a man who not only was a rural person who understood the difficulties in the rural districts, but he also came into Washington on business, he was sent on site visits by the RMP and learned a great deal about the whole

complex works, so that he is a sophisticated man, and yet he is a man who has knowledge of the small rural community's mind.

I think he has done a very successful job in that Region, through a traumatic experience, and I believe they have done the best we could possibly expect from them.

I agree with Doctor White's recommendation for the funding, and I would urge that we give them what they ask for at this time, even though I think perhaps the question he raised about the cancer projects may have some validity and that those possibly can be transferred.

I would like to turn in this long-winded written affair so that it does not take up your time, but it has comments on a number of the projects. Is that acceptable?

MR. CHAMBLISS: I am sure the staff would be most appreciative of your notes, and they will take into account your concerns, Mrs. Wyckoff.

MRS. WYCKOFF: I have some grave questions in here about the relationship of CHP and RMP in terms of their funding, and the agency that is going to pass judgment on -- the agency that funds it now and how you work out these relationships in a satisfactory way, but I assume that with the new legislation, all this may become academic.

So I would like to second Doctor White's motion that it be funded at the requested amount. I think they are capable

WHD-11

of spending the money --

DOCTOR WHITE: I suggested the targeted amount.

MRS. WYCKOFF: The targeted amount.

MR. CHAMBLISS: The matter before the Committee now is simply a suggestion, and I would certainly entertain a motion.

MRS. WYCKOFF: All right. I'll make a motion to that effect.

DOCTOR WHITE: I'll second that.

MR. CHAMBLISS: It has been so moved:

"That the level of funding for Colorado-Wyoming RMP be set at $1,587,644, which is the equivalent of the targeted amount for that Region."

The Committee has expressed its concerns with regard to the cancer activities and --

DOCTOR WHITE: Kidney.

MR. CHABMLISS: And the kidney activities as embraced in the motion.

That has been properly moved and seconded. Is there discussion?

In the absence of discussion, I'll call the question. All those in favor?

(Chorus of "Aye.")

Those opposed?

VOICE: No.

WHD-12

MR. CHAMBLISS: The motion is carried, with one negative vote in the person of Doctor Miller.

It is so ordered.

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:WHD-13

MR. CHAMBLISS: I would simply like alert the Committee to stand guard for some momentary changes in the order here.

I have pointed out one, that Doctor White will have to leave, and we will take Georgia next so as to permit his temporary departure from the Committee, and then I would call to your attention the fact that our staff support for Illinois, Mrs. Kyttle, has to be out of the room, and I might say that she is one of the persons who has transferred from RMP. She has to be out of the room momentarily also, and she will return around 4:00.

We would then substitute Indiana in place of Illinois. We would make a change in Inter-Mountain and Iowa, and pick up at Kansas, Louisiana, and move down from that point, so there are a few changes that I would ask the Committee to take cognizance of.

We will now call upon Doctor White again, and Doctor Carpenter for a review of the application of the Georgia Regional Medical Program, and they will be supported by Mr. Jewell, from staff.

WHD-14

REGIONAL MEDICAL PROGRAM REVIEW

GEORGIA

DOCTOR WHITE: I'll follow the same general format, but in reality, comments are very akin to those made previously and only the names need changing, in a sense.

Georgia is in a triennial status. It's been awarded that in the past in recognition of its quality; again I have the advantage of having made two previous site visits to that Region, and have come to know J. Gordon Barrow professionally reasonably well during those two visits.

I think one can say, without too many reservations, that Doctor Barrow is one of the better Regional Coordinators. He is the original and only one in this particular area; even prior to his activities in the Regional Medical Program, he was very active in similar sorts of activities in the State of Georgia.

He has the appropriate accent, and is well-accepted by one and all in that area, and he has done a commendable job in establishing a very close relationship with the Georgia Medical Association -- or Society; I've forgotten which it's called -- so that they are the sponsoring fiscal agency.

There has never been this conflict of interest which seems to have arisen in certain regions between established medical organizations and the medical programs.

He has indeed cemented relationship, both in Atlanta,

and clearly out in the regions of Georgia.

At least on my previous site visits, it was my feeling that the people in that area who attended the visits, have come to recognize that the Regional Medical Program of Georgia was indeed a resource upon which a wide variety of people could call for help, ranging from patients to health professionals.

The staff, again, consists of thirteen key and stable people who have been there an average of five years and three months, and again, are well-qualified in terms of their backgrounds and degrees for positions that they hold.

They are organized well into administrative and operational groups with defined responsibilities and areas of operation.

The Regional Advisory Group has continued to be active; it meets regularly. In their words, it did not wither, it developed alternate plans, not just for the phase-out, but for its continuation beyond the time when support would wither. It even conducted a "retreat" which was apparently well-attended by most of the members of the Regional Advisory Group, in which they examined the alternative plans for survival with or without Washington's support.

Again, it is clear that the individual members of the Regional Advisory Group not only participate in the deliberations of the meetings, but participate in terms of

serving on committees, making site visits and interchanging with Comprehensive Health Programs throughout the state.

Its past performance has sometimes been misunderstood. It also has this regionalization, or "umbrella" sort of concept, and in the past we have kind of thought at times that they were continuing an old activity under a new name, but in reality they were continuing a new activity under an old name, is what it amounted to.

And they have gone out and they have used community hospitals as a source or a center from which to spread out, creating a net of educational care facilities, investigation and the like, and the only question I saw in the whole application was whether or not they should broaden out and no longer use just -hospitals as a center, a focal point, but perhaps that there are other kinds of health agencies that could also serve this function as well, but that was a comment.

They have indeed established well-defined catchment areas and regions which subserve their projects and programs and activities, and by virtue of this they also have a close relationship with the area Comprehensive Health Planning agencies.

It has an Emergency Medical Services project which is largely that concerned with planning and coordination. Its continuation by others at the present time is not clearly specified. There is no hard money, or firm commitment by any

WHD-17

other agency or organization which indicates that it will continue, but presumably something might arise on the scene.

Its objectives and priorities have been well specified in the past, and are unchanged at the present time; they still have to do with availability and accessibility and development of new types of manpower and utilization and networks of specialized services.

It also is undertaking a fairly extensive program for planning and developing health resources, and I guess this raises a question in my mind, particularly after hearing Doctor Paul's comments this morning, that although these Regions have been encouraged to do this, what is going to happen if they expend a lot of money, a lot of time and a lot of effort meeting, getting together, saying "This is what the health resources facility should be for the State of Georgia," and in the meantime Congress is passing a law which is diametrically opposed to this sort of thing?

Is this something that we should attend to? Should we say: "No, let's not be doing that until we see, when the dust settles, where we're going to go." Or should we hope that by virtue of their doing something now they'll have some future influence on Congress? I don't know.

Their relationship with Comprehensive Health Planning, I believe to be good. They exchange memberships on the respective committees and Regional Advisory Groups and

WHD18

boards; they have funded one another for certain types of activities, there are certain adequate letters of support from the Comprehensive Health Planning agencies, without serious adverse comment.

I think it is important to notice also that they have not -- even though they were told they might expect 140 percent, they have not chosen to ask for it, and they have also indicated that they felt they would not be asking for any money in July.

They have given considered thought to what it is they would like to do and they want to get underway at the present time, and it is going to take less money than they thought they may possibly be awarded.

It seems to me this does reflect some thinking, some merit. This is a Region of merit, a Region of past performance, and I would feel they are entitled to what they requested, or any fair proportion thereof that is finally evolved.

MR. CHAMBLISS: All right; our next reviewer for Georgia is Doctor Carpenter.

DOCTOR CARPENTER: Well, it is always a pleasure to follow Phil, because he makes it so easy.

I would just -- this application was an enormous relief to me. I thought in some areas that maybe I was wrong about Regional Medical Programs, and I found that if I was, at

WHD19

least Gordon Barrow in Georgia agreed with me.

So I can hardly say enough good things about the Region.

You know, for instance, they don't charge indirect cost rates, except on a few -- I don't know: 76-46 -- less than $100,000 in the total program of nearly three-plus million dollars -- less than $100,000 of indirect costs.

They have their own goals; they are leading the development of the health-care system in Georgia, I believe, as much as any organization I have ever seen lead in such a complex environment as the state, among its health care providers and interested consumers.

They have their own goals and they are pursuing them actively, but they take full advantage of Federal priorities, and move in new areas with amazing speed.

They have responded to the minority problem very well; there are -- there are a large percentage of minority people, particularly in the projects. They --

I am tempted to read two paragraphs out of the projects, because they contrast so much with the Arkansas descriptions and some of the other ones I have seen -- not really trying to single out Arkansas, but to make the point that these people do have specific goals, they do indicate in their project descriptions their understanding of the pitfalls in developing. You know, no matter what you try to do, there are

WHD20

always problems, and they indicate, I believe, that they are aware of the importance of the problems.

And I could go on and on, but I would agree with Phil's funding recommendation, and I would make a motion then that we approve support of the level requested.

DOCTOR WHITE: I'll second that.

MR. CHAMBLISS: There is a motion that:

"That the funding level for the Georgia Regional Medical Program be set at $3,629,757, which is the total amount requested by the Region."

MR. VAN WINKLE: And you might note that they don't propose to come in July 1.

MR. CHAMBLISS: Now that you have heard the motion, is there discussion? Mr. Thompson?

MR. THOMPSON: Some people may not know that they have had probably the most successful EMCRO program, which was an Experimental Medical Care Review Organization, and they have been designated, I think so far, as the only statewide PSRO, which also indicates the kinds of togetherness that somehow this state manages to put together.

MR. CHAMBLISS: All right; further discussion on Georgia?

Then I'll call the question. All those in favor of the motion, please say "Aye."

(Chorus of "Aye.")

JHD21

And those opposed?

(No response)

There is no opposition, and I would simply say to the staff, as they convey to the Council, the observations -- the recommendation made about the Region in addition to the level of funding support recommended.

I would ask Doctor White, in that he will be leaving shortly, if he would be kind enough to prepare the review sheets, and we would very much appreciate that, and you likewise, Doctor Carpenter. Thank you.

DOCTOR WHITE: The question arose: do you want these signed? Should they be signed?

MR. CHAMBLISS: We have no aversion to them being signed; it is not required, but if you like. We can be much more specific in our observations.

DOCTOR WHITE: You know it comes from one of two people anyway.

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MR. CHAMBLISS: I would indulge the Committee and Doctor White for one further observation here, and that is that Doctor White is also scheduled to review today the application for Louisiana.

Would you be disposed at the moment to continue, Doctor? Or would your time not permit?

I only call upon you on that momentarily. It is not required, however.

DOCTOR WHITE: Well, my hesitancy reflects the fact that I don't see Doctor Perry here.

MR. VAN WINKLE: Doctor Perry will not be on the Panel.

DOCTOR WHITE: Therefore, I am the only person who is going to have any say-so about Louisiana, I guess.

MR. CHAMBLISS: You will have support from staff, however, in the person of Mr. Zivlavsky.

DOCTOR WHITE: It would make me more comfortable to do it at a later time.

MR. CHAMBLISS: Indeed so; no problem at all.

I would then call the attention of the Committee to the application from the Indiana Regional Medical Program. The reviewers there are Doctor Slater and Doctor Thompson.

I have skipped Florida. I would -- if the Committee will indulge my mistake, I will change that and revert back to Florida, and then come to Louisiana. I would thereupon call

WHD23

upon Doctor Miller, who will be supported by Mr. Van Winkle, from staff.

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REGIONAL MEDICAL PROGRAM REVIEW

FLORIDA

DOCTOR MILLER: I probably have a little bit different point about many of these things than many other members of this Committee, having directed a Regional Medical Program for seven years, and I tend to be a little critical, which I hope you'll bear with me, and I won't feel offended if you vote down my views more liberally than I make judgments.

Florida, our Regional Medical Program has been an outstanding RMP; for a long time it has the second highest current level of annualized funding, according to our list, under California.

It is an ambitious RMP; it has always has an ambitious program. It is well organized, with good leadership, good program staff, excellent Regional Advisory Group, excellent past performance and accomplishments -- I could go on and give details of these things, but there is not much point. They are all very good.

Their objectives and priorities are not quite so succinctly specified or controlled, but nevertheless do address the program activities, address all the key issues that we focus on.

I can't find anything really wrong with any component of their application, which is large, for three million dollars; the staff's only question for Reviewers' attention was the

MAST program, which is an EMS component, but staff didn't feel that there was any problem here.

So the proposal, the operational activities and all, are indeed congruent with the Region's explicit priorities and suggested areas of emphasis, and they get along well with CHP, and the CHP relationships are good.

So then you get down to the problem which I addressed in all of these five that I reviewed in detail, under a couple of basic principles.

The first one was that virtually all the RMP's should be given complete support for their core staff and for continuation of program activities that they have gotten started and that have been going all right.

But then -- provided the budgets are not doubled or tripled, that is.

But then the problem of new projects and the feasibility of getting them completed in a successful way, with a meaningful impact, with recognition as an RMP activity, in one year, seems to me to be quite a big question.

The staff did not summarize, in the Florida program here the answer to the question:

> "Are continuation projects budgets raised too much for the next year, out of proportion to what they have been this present year?"

And I would like to ask staff if that is true, because a

number of these projects have rather large budgets, much the same, however, as you have just reviewed in the Georgia program, with rather tremendous individual budgets for some of the program activities.

And in Florida, in the Florida RMP, the numbers of -- lost my page here, but there are something like -- 35 projects, of which 25 are new, I believe. 22 are new, and not previously funded, and if one goes into those projects, there are a number of them that are certainly very questionable as to whether they can be successfully and very conscientiously completed in one year, activities that would be worth the rather large budget requested.

The bilingual communications system of translation from English to Spanish, of $121,000, without any real indication that it is going to be continued by anybody else.

A number of these. Visitor assessment of visitor's needs for health care of visitors to Florida, with a budget of $189,000, a Florida perinatal program, which is an obviously needed thing, but with a budget of $212,000 and no real indication exactly as to whether they would be continued, except to say that efforts would be initiated to try to find out if they can be continued. One would hope so, for $212,000.

Improving health care assessment quality assurance, which is an excellent plan, in community hospitals. Anybody who has worked in one of those things, in those endeavors,

which we did, knows that there is a very limited amount you can accomplish in one twelve-month period and a budget of $212,000.

A program to start a mid-wifery project, which is obviously very much needed in many places in this country but it is one mid-wife with a budget of $87,000.

An Indian health care program for acute critical illness in Indians; we started developing one of those in Minnesota, figuring it would take at least three years to get it going.

So, I find myself being critical of dealing out rather tremendous amounts of money, even to what I regard as one of the best RMP's in the country, to activities like this that have relatively high budgets and, I think, somewhat questionable potential for comparable achievement.

Now, if the RMP was likely to be funded for another three-year period, every one of these things would be good, and they would be ahead. We'll come to Missouri later, and I think the situation is similar there. They would be ahead of the game, because they would have started things, moved very rapidly in their very large endeavors, and then moved right ahead then with some critical key issues and have a year's head start on a lot of other programs that then will start three-year projects of such things.

So in terms of that, obviously one should okay

their funding.

They also plan to come in for another application in July, for another one and a half million dollars.

So they're not modest. They are good, but not modest. Applying for a total of four and a half million.

I fail to be able to differentiate the charge to us of reviewing these things without considering these cost-benefit aspects of particularly new-project activities, and consequently -- well, my first recommendation after studying all this was that they be cut by a million and a half.

I guess, in view of what has gone on this morning, I would say that was an unusual recommendation, and therefore I would -- well, I would like to hear Staff's reactions, since the other Review Committee member is not here.

MR. VAN WINKLE: In terms of the continuing support, Doctor Miller, I can only go on their past record, which has been excellent. That has been one of their main objectives in their cost-sharing of funds, and I just noticed the one statement in here that since July of '71, $3.7 million have been invested by the Florida RMP, and that was augmented then by $5.2 million of other funds that they were able to drum up, and then after completion of the FRMP support, they continued a number of those projects with other funding in the amount of another one and a half million.

So they have had a very good record of continuation

after their phase-out.

Now, I noticed, too, some of the large increases in budgets, and did check this out, Doctor Miller, and particularly on their continuations; their budgets were jumping very high.

DOCTOR MILLER: Oh, yes; maybe twofold.

MR. VAN WINKLE: And what I found out is that we were comparing against four-month budget; the previous budget that you were looking at was only for a four-month period.

DOCTOR MILLER: I did not have the previous -- they are not in here, the previous budgets.

MR. VAN WINKLE: No, but I went back to check, and it looked like a horrible jump, but then when I annualized that against this, and as an example, I just pulled one out here.

They had started out only in two counties, and it was a pilot study; they now are moving out into all 67 counties of the state.

The one on the next page, for example, was a pretest pilot program in three hospitals. They are now moving that computerized system that they developed into a statewide program now.

And as I went through each of these, I found that -- you know, that type of justification. The one on the community organ-donor program, that started only in Dade County; it

VHD-30

is now moving out into four surrounding counties around Dade, and it will increase the capability.

And I think one other thing I would like to mention about Florida, along with the other good things you say, is that they also do not have an indirect cost rating.

DOCTOR MILLER: No. They are a separate corporation which has its costs all direct.

MR. VAN WINKLE: I am not sure what other -- I really can't say anything as to the continuations, other than the fact that their past record has been excellent.

DOCTOR SLATER: May I ask a question which bears on the indirect versus direct charges?

Are the direct usually less than the indirect charges being made by universities or other institutions?

MR. CHAMBLISS: Yes, they are.

DOCTOR SLATER: Considerably less?

We seem to be very concerned about the indirect costs that are charged to the program. I am just trying to get a fix on the difference in amounts, or a percentage, let's say.

MR. VAN WINKLE: Well, let's assume that you had a two-million dollar grant to a program. You might have another 80 percent of that added on to that, that we have to put out in terms of indirect costs.

DOCTOR SLATER: Right, but if you build the direct

ID-31

costs into the two million dollars, what would that total package come to?

DOCTOR MILLER: I can answer that partly.

It depends a lot on how the big institution handles its accounting for indirect costs. If the big institution, now, like a big university -- we ran through this in Minnesota, because a part of ours was a university component and may have indirect costs -- now, if the university figures its indirect costs across the board, with all departments, which includes all laboratories and research units and so forth, and they got all the costs of all those research units built into the total indirect cost rate, then a desk operation like RMP is charged an exorbitant amount of indirect costs.

If however they have two levels -- and they frequently do -- and they cost-account indirect costs on the basis of the kind of work we are doing, then it is -- it may not, depending on how efficient the big organization is -- their indirect costs may not come out any bigger than if you do a direct cost.

MR. VAN WINKLE: Doctor Miller, you were talking about this Region looking ahead, and that is precisely what they are doing during phase-out. They did not stop.

They said: "No way are we phasing out;" they never at any time believed they were going to phase-out and they continued their program, and when the June 15th turnaround

came, they were way down the road. That is precisely the way they are going to look at it right now.

DOCTOR MILLER: I expect that is precisely what they are working on right now.

MR. VAN WINKLE: They intend to be whatever organization that is that responds to the new legislation. That is their intent, whether it has anything to do with this application or not -- but I do know that is their intent.

MR. CHAMBLISS: I might simply suggest to Doctor Slater, if I may, that as we move from the world of foundations to the world of institutions, this issue will become a very keen one, about indirect costs.

DOCTOR SLATER: I'm sure it is.

MR. CHAMBLISS: It is one that has been rather perplexing for many of us.

DOCTOR SLATER: Foundation spending is very simple, by simply saying:

"We never pay anybody more than 15 percent, if that; we can't do it."

MR. CHAMBLISS: I wonder if the Reviewer, Doctor Miller, is now -- are there further questions? I would entertain -- I would like to have a recommendation, and I see Doctor Vaun's hand.

Doctor Vaun, did you have a question?

DOCTOR VAUN: Yes. Winnie,you raised the question

about the possibility of these projects after a year, or the possibility of accomplishing the objectives and goals within a year.

I wonder, if in the stage of transition now, that is a legitimate question? Not considering Florida's past performance, but I wonder if that is a real question on our part in this panel? I would just like some reaction to that.

To me, it sounds like you are questioning the whole management ability of that program when you ask that question. In other words, if they didn't think that there was either a reasonable chance of follow-through with funding from other sources, or a reasonable chance that they would accomplish their objectives, than how can you say in one breath that it is a reasonably well-managed program, and yet you have sizable questions about the money?

DOCTOR MILLER: When RMP's first started, the RMP was a source of "soft gold" from the Federal Government. I went through this, in the process of getting people to change, because these are the kinds of budgets we had in all our applications. They were huge.

Now, it is quite obvious -- if you haven't heard it, but it has been expressed very widely -- RMP is now another source of soft gold for one year, only. All the frozen money has been released, and RMP now has more money in one year than they had before.

D-34

Now, I don't -- maybe you don't -- I'm not sure that it is politically desirable to try to react against that at this circumstance.

MR. VAN WINKLE: Doctor Miller, I am familiar with the review process. I have been at some of their meetings, and it is probably one of the toughest groups I have ever encountered.

As I mentioned to you this morning, at the last RAG meeting I attended, they became so personal I almost wondered if there was going to be a little bloodshed.

Staff are involved with the development of that program from Day One, and long before many of those proposals ever come to the first committee in the review process, Staff has already been at work on their budgets.

They have two different review groups that have a go at those, and again, you can get reductions in any one or all three of those three review groups. I sat through one on a Saturday, and then on the Sunday I thought all the slashes had been made, and then went to the Council meeting on a Sunday and found out that it was not resolved at all.

DOCTOR MILLER: Yes. The letter says that it had over 100 projects applications that they reviewed.

DOCTOR CARPENTER: How many did they accept?

DOCTOR MILLER: 35.

MR. THOMPSON: May we arrive at some kind of money

here?

MR. CHAMBLISS: The Chair would entertain a motion based on the presentation.

MR. THOMPSON: I'm not going to let him off the -- off the hook; he hasn't made a recommendation.

DOCTOR MILLER: All right.

They are planning on coming in with a million and a half more application. Their target total is $3.2 million, they are applying for three million now. Their current funding level is $2.3 million.

I would recommend a funding level of $2.7 million.

MR. CHAMBLISS: The recommendation is a funding level of $2.7 million for Florida. Is that in the form of a motion, Doctor?

DOCTOR MILLER: If you wish.

MR. CHAMBLISS: And is there a second?

MR. THOMPSON: I will second it.

MR. CHAMBLISS: It has been moved and seconded:

"That the funding level for Florida be established at $2.7 million."

Is there any discussion?

(No response.)

If there is no discussion, are you ready for the question? Those in favor?

(Chorus of "Aye.")

Opppsed?

(No response)

The motion is carried, and it is so recommended, at $2.7 million.

I would say that the Committee is moving along rather well, and that we will go to the next Regional Review, and that is Indiana.

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WHD-37

REGIONAL MEDICAL PROGRAM REVIEW

INDIANA

MR. CHAMBLISS: Indiana will be presented by Doctor Slater and Mr. Thpmpson, supported by Mr. Jewell.

DOCTOR SLATER: All right, sir, I'll begin with Indiana.

The budget request, as you have seen on Line 43 of the print-out there, they are annualized now at $1,057,000, and they are requesting $1,221,000 against a targeted fund of $1,430,000, so they are considering about 84 to 85 percent of what they are targeted for, but coming back in July for another $400,000, which would bring them up to about 112 percent of their current.

I looked at the proposal and tried to sort it out in the sense of the guidelines that you gave us, and let me introduce this by saying that I found it very difficult to come to grips with what they are doing.

When I looked at the specific projects that they have been involved in in the past, and what they have been able to accomplish, I am impressed that something is going on out there, and I do believe they can't write a proposal very well, or write a report. I found repetition and lack of clarity, and so I think that I am going to reflect that.

I would say that this is a traditional type of RMP program in contrast to the one I'll report on later in Illinois.

WHD-38

Program leadership is satisfactory.

Program staff -- every one of the current staff have been in RMP for over four years and they have experience.

The non-medical professional people, with the exception of the Dean, who has been associated with the school and the program support for some time, are now instituting themselves to the level of 33, with good representation in Indianapolis and the regional areas.

At the 37 level, they had 30 people from Indianapolis and seven from the regions. They are now going to try, in their new level of 33, develop a better balance for minority and geographic representation.

They have the usual types of committee -- Executive, Review, Evaluation and so on, which I thought was satisfactory.

They outlined that they have two major thrusts; they attempt to develop guidelines on standards and criteria on two main types of activity.

One, the identification of hospitals to provide better capability there, with particular reference to state emergency medical services, and secondly, they are interested in enhancing a whole series of specific programs which have to do with quality of medical care, access and the like.

These are identified as renal dialysis, kidney-transplant, radiation therapy, angiography and the like.

WHD-39

Now, as far as past performance is concerned, they describe themselves as really spearheading regionalization and improved cost-effectiveness by acting as coordinators, planners and developers, and I wrote a quote here:

"They are interested in more quality of health care available to more people at less cost."

That, I thought, was a nice, general "motherhood" statement.

Within that framework they really have been working closely with CHP, and have been attempting to extend sub-regional RMP development that is tied in with the existing B agency development in Indiana.

Examples of what they have done in the past, very briefly, are that they have developed a data base to reveal health deficits. I am not quite sure what that means, because there wasn't enough information.

They have organized sub-regional CHP provider-consumer groups in six areas, five or more on the Board.

They have promoted programs to meet these above needs. For instance, physician-extender and continuing education programs, they have been involved in legislation on statewide emergency medical services, a couple of neighborhood health centers in the urban areas, state stroke-therapy services, consultation in organized coronary-care units -- I could go on.

All of the above, with the exception of a little bit

of continuing RMP staff and money input, have been initiated and are on-going and phased over to other support. They are not totally independent; where the line is drawn, I am not sure, but they have made a major effort to act as a catalyst and move programs they started out onto other funding lines.

At the moment, they also have some limited demonstrations; hypertension screening and care programs in disadvantaged urban areas. They are looking at what they call the "assurance of quality of care." I wish they had just said they were setting up a perinatal upgrading program, instead of all the generalizations.

They have a kidney disease program which includes immunologic studies. This is a hope to define ways by which you can prevent organ rejection. I was concerned about this because I think it should be funded by -- it is a basic science study and should be funded by some other method.

Now, the objectives and priorities -- after all these years of effort they had a mail poll recently among 25 RAG members and 65 non-RAG members, and they carefully itemized what they came up with, and honestly, it is what you put together as a first-run ten years ago.

Continuing medical education, needs of under-served areas, emergency medical services, hypertension, innovative health-care strategy -- it's all over the map. But it's traditional, in the sense of what many RMP's consider to be

WHD-41

the umbrella approach of improving the quality of medical care.

At the moment they are moving ahead with the hope of having two major thrusts. They described this as expansion of the program staff -- and I need some help from Staff on that if John hasn't got a better understanding of it. -- and regionalization.

Within that framework they then present a proposal which moves along lines that include emergency medical services, for which they already were able to achieve 1974 legislation, which only provided them $75,000 for the state, so they are asking for another $95,000 to enhance that program until they can get better funding from the state.

They are also wanting to have help for health-resources planning in cooperation with the six CHP exksting B agencies.

On page 25, they outline, in three or four lines each, 13 new activities for which they have planned a July application, which amounts to $400,000.

In the present proposal they are asking for $616,000 -- I believe it is -- for new program staff, and what I don't understand from their proposal, and maybe the Staff person here knows, is whether or not the $616,000 of new money for program staff is to program that $400,000 of 13 new projects. I don't know whether they are interrelated or not.

The specific projects range across the board. They

want a kidney-transplant exchange information system -- only $8,776, and what this means really is to computerize in their Southeastern Regional Organ Procurement Program the 8,000 tissue types scattered among the population of people who they can count on to contribute organs.

I would gather that that would pay for a computer clerk, or something. It is a tremendous program to buy for $8,776.

The second point was care for hypertension patients in Marion County, which -- for $141,000. That is a specific center model they want -- they want to fund the equipment and overhead on a center in which screening, clinical care -- screening, clinic, diagnosis and treatment, including nurse-practitioner follow-up of these patients, can be gotten off the ground. They want to be able to acquire data, study, study the compliance rate of these people in this deprived area.

They are looking for the development of a statewide "tele-medical" system, which is really a telephone-answering service, for $41,000.

They are looking for the development of -- as I mentioned earlier -- quality assurance, which is really improving perinatal infant death, in Marion County, where they have again inner-city high-mortality rate. They are attempting to put together six hospitals to do mortality reviews, with the

idea of upgrading the performance of the doctors as well as patient compliance; that to be done for $23,766.

Those are worthwhile projects -- most of them are very worthwhile.

Looking at the feasibility of all of this, I found it a little difficult to assess. I assumed -- I gave it a "satisfactory." I can't tell on the basis of the way the program is written, even in the terms of past performance.

The relationship with the Comprehensive Health Planning, I would say, is very close, insofar as the evidence shows.

Overall assessment of this, I gave average, or C-minus, largely based on their inability to present it very well. Again, I come back to the fact that they are overly general and euphemistic, lacking specificity in the writeup, but on the basis of what they have already done, it looks as if they are capable of performing reasonably well.

John Thompson and I looked at what might be pulled on this, and I think we feel the Emergency Medical Services is open to question with regard to that $95,000. I question whether or not we should be funding the kidney disease immunological rejection studies; you mentioned the dialysis -- kidney dialysis program as well.

I need specific information on what the $616,000 for program staff is aimed at. I somehow just could not decipher

that. So I will leave my final comment up in the air, except that I do believe that despite the fact that they are only asking for 84 percent of the targeted funds, they still may be asking for too much at this time, with this type of application.

MR. CHAMBLISS: All right. Our next presenter, Mr. Thompson.

MR. THOMPSON: I am very much in agreement with Bob's evaluation. It is very difficult to understand what the goals and objectives of this particular program are, because they are stated in such general terms, you know, like regionalization -- that's a goal.

The nearest thing we can get -- and the only reason I can pick this up is because it was underlined -- is the development of innovative programs in health-care delivery to -- with special emphasis on under-served geographic populations and medical areas, and on public and professional education about health-care matters that will assure quality and cost-effectiveness of service.

If those are their goals and objectives, none of the particular programs that we are asked to review have anything to do with those goals and objectives.

The second -- I'm not quite as obviously optimistic about the relationship with CHP, because every reference to CHP -- and I would like to have Staff input -- is very care-

WHD-45

fully phrased.

For example: "Communications have never been so good as they now are with CHP."

Well, I have been in areas where, if you said "hello" and somebody said "hello" back, between the two people communications had never been so good! Because before they wouldn't even talk to each other.

I can't operationalize that kind of a phrase.

The staff is over 72 percent of the total request -- over 72 percent of the total request is for core-staff, and the reason I am concerned about the EMS component is that it specifically states -- in one of the few specifics in the whole thing -- that, and I quote:

"The general objective of this project is to develop an areawide EMS system adequate for the needs of those counties constituting Region 7."

So that is obvious that they are building an EMS system, and whether this system is in conflict with that or EMS or not, I think we ought to define.

I am certainly not turned on by that "Dial-a-Disease" project which they have, where you dial in someplace, and they slam on an Ely Lilly cassette, I think, that tells you all about the problems of the man over 40, and about --

(Discussion off the record)

MR. THOMPSON: But, to continue, I would rate it as

poorly as Bob did, and certainly not give them the amount of money they asked for.

But on the other hand, if we want to maintain the capacity for this outfit to do something, and 72 percent of the whole project is staff, you can't cut it too much, so I recommend a cut of $100,000, from what they request, to bring it down to --

DOCTOR SLATER: To come back on to that staff, the staff request, the other support services that are involved with staff, come to not $616,000, but $882,000, and that is really to improve the Emergency Medical Services system development, Family Practice program development, integration of Comprehensive Health Planning and IRMP activities, hospital access studies.

A lot of this has to do with data collection and planning. They see themselves as the planners for Indiana, as far as I can make out, including the CRMP. The CHP group -- excuse me, and I guess I need clarification as to whether or not this is real.

MR. CHAMBLISS: I would ask -- we are cognizant of your recommendation in terms of the funding level, but I would ask, are there any inputs as it relates to CHP for that state -- for that Region?

MR. JEWELL: Which question should I answer first?

MR. CHAMBLISS: Answer the Committee's question

VHD-47

first.

MR. JEWELL: On CHP, Mr. Chambliss, this is a continuation application, and about two months ago I was out there to their wedding of RMP and CHP, so we were wondering what the children were going to look like. But they had the A agencies, and all their B angencies are funded, and I was surprised at the quality of men that I met up they -- and -they were all men.

This was a two-day meeting, where they got in a room, in a motel, and laid it out -- what they had not told each other, what they wanted to tell each other -- so I can only attest to the viability of the statements in their cover letter, that what I witnessed there on one visit was a very useful, viable discussion, and I am not really that much interested in meetings.

Doctor Slater, on your request for program staff, sir, there is $616,000 that they are pulling out, and it will be funded under the program-staff component, sir.

It will not buy new people, and this is for RFP's, if you will, sir, to address these priorities that they have listed on the last page of the application. EMS, Health-Resource Planning Criteria and Standards, Arthritis Study, Cancer Control --

DOCTOR SLATER: The 13 new projects?

MR. JEWELL: Well, they are contracts; yes, sir, but

HD-48

that would just be funded out of the program staff component. There are -- their actual program staff request, money-wise, is about $265,000.

DOCTOR SLATER: They are only going from 9 to 18, so I see. What this means, then, is that that money is to provide for contracts for people for work to be done in those 13 areas. I see.

MR. JEWELL: Yes.

MR. THOMPSON: Are they going to have their contracts finished in time for July submission?

MR. JEWELL: No, sir; no, sir.

DOCTOR SLATER: They have another $400,000.

MR. JEWELL: This is for the next year, Mr. Thompson. These are two separate groups. Their other hopes and submissions for the July submission are, I think, on page 25.

DOCTOR SLATER: I was wrong about the program staff, John. The program staff is to improve the contract for more Emergency Medical Services, to help develop their system for the Family Practice Program Development Integration of Comprehensive Health Planning with the RMP.

That is what the $616,000 in contracts is going to be for; is that correct?

MR. JEWELL: Yes, sir.

DOCTOR SLATER: Maybe it was here, but I didn't get

that originally.

MR. THOMPSON: What are we going to recommend?

DOCTOR SLATER: Well, we will recommend $100,000 less, and with recommendations that this be applied to what -- the immunologic?

MR. CHAMBLISS: We get a sense of your recommendation; we will ask that that be placed in the form of a motion momentarily, but I would simply have the Committee note that there is a representative here from the HEW Region Office 10, which in Indiana is a part of that regional configuration.

I would simply call upon Mr. Wally, if he wishes, to make a statement regarding that program or regarding the CHP-RMP relationships, and he may do so at this time.

MR.WALLY: I am not that totally familiar with it, but I know that in Region 5 we are encouraging a merger. We are encouraging a merger, or as it was put before, a marriage between RMP's and CHP's in their approach to the whole comprehensive health program.

So you may find that that sort of seems like ambivalence on their part, but we are encouraging them.

I guess this is optimism on our part, that new legislation will encompass that kind of a framework.

DOCTOR SLATER: It may be too late, but I would quietly recommend that they get somebody else to do the writing of these proposals, sharpen the focus and reorganize them

better.

MR. THOMPSON: To you there were three questions.

There was the CHP-RMP; there was the program of specifically-stated EMS programs, and the very scientifically based renal programs, specifically in the project itself.

Now, I think the Staff person can answer fairly well; they are doing RFP's or something, rather than increasing staff, to explore further programs, but we still are stuck with the problem that there seems to be very little relationship between the goals and objectives as stated on page 19 of their report, and the programs we have been asked to review, which, in fairness to them, all have been continuation programs.

MR. CHAMBLISS: The Chair is open for a motion here. Will you so move the recommendation that you just made, Doctor Slater?

And that motion, as I gather it to be, is:

"That the Regional level of funding be recommended at $1,121,159, and that due notice be given to the CHP relationships, the renal aspects of the application and the EMS."

MR. VAN WINKLE: What about the CHP relationships?

MR. CHAMBLISS: It has been moved and seconded, and is there discussion?

MR. VAN WINKLE: I want to be sure of this, because

we are going to have to take the message about it to them.

DOCTOR VAUN: Carrying through the theme of the illicit relationships, the reason I say that is that one of the ways to avoid CHP comment is to put $600,000 in a slush fund.

MR. THOMPSON: Most of which is devoted to tasks that CHP ought to be looking at.

MR. CHABMLISS: Is there further discussion?

Question? All those in favor?

(Chorus of "Aye")

Those opposed?

DOCTOR VAUN: No.

MR. CHAMBLISS: Doctor Vaun is in opposition, and the "Aye's" have it; the motion is carried and Staff will take due note of your observations, Doctor Slater, regarding the over-generous non-specific writeup of the application.

DOCTOR SLATER: Which I rated as C-minus, by any elementary school standards. I am very unhappy with this; I am very unhappy with the amount we have given them, I don't know what to cut it back to, because it is almost impossible to make a judgment.

MR. THOMPSON: I think a critical question is whether the $600,000 was a dowry or a bribe.

MR. CHAMBLISS: Those are two legal phenomena, and the Staff will take note of them.

DOCTOR WHITE: I won't cast a negative vote; I will just abstain.

MR. CHAMBLISS: I think those of you on the Committee who are interested in measurements would like to know that we are 66 percent through our workload for today, we are now 35 percent through our workload for this panel.

It is getting close to 3:00 o'clock, and those of you who would like coffee may have a chance; those of you who would not like to have coffee and would rather have it later on today? I am with you and we can proceed; it is left to you.

(Discussion off the record)

MR. CHAMBLISS: Would you like a break?

DOCTOR SLATER: Why don't we take a break and bring it back to the table?

(Whereupon a short recess was taken.)

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WHD-53

MR. CHAMBLISS: All right; I would like to reassemble the Committee and lay out a suggestion for you, in terms of what we might be able to do today.

If we could consider the regions in this order, I think it might lay out for us a work-plan for the balance of the day:

Wisconsin, coming up first.

Kansas.

Michigan.

Mississippi.

Missouri, and perhaps

Illinois, and

Louisiana.

If we could make that accomplishment today, we would be well into tomorrow's work and that would mean we would have completed half of our regions.

I hear the words "let's go," and I am ready, and I hope you are.

I would then call upon Doctor Carpenter and Doctor Scherlis; I will call upon Doctor Carpenter, and Mrs. Parks as his Staff support, to now begin the presentation of the application from Wisconsin.

REGIONAL MEDIAL PROGRAM REVIEW

WISCONSIN

DOCTOR CARPENTER: Thank you, Mr. Chambliss.

This one is to some extent a rerun of what we have heard before. The Region has, as you have heard this morning, lost its distinguished coordinator, and so we have a Region with a very illustrious past history that now, I believe, judging from the rather poorly written application, is in a crisis of leadership, and so it is hard, first of all, to know whether -- again, whether it is just that the words did not get on paper, or whether the leadership really is going to be a problem.

I think I have no way to judge that it won't be a problem, and so you can see something about where I start.

The program staff and professional staff -- well, it is worth noting that they are asking for a 276 percent increase in their funding, and the program staff has fallen to eight professionals.

The Advisory Group is not -- it has met three times or so, but not accomplished anything that is too clear in terms of responding to the vicissitudes of the recent past.

I think past performance has been quite good. They have terminated 18 projects, and all but three of those are still operating in the state, in independent funding.

The objectives and priorities are very vaguely

WHD55

stated; they seem to be little more than a description of Federal priorities.

Except for this evidence of past performance, there is no evaluation to speak of of what is going on now and the projects themselves have vague goals; frequently there are multiple projects in a single area, and no evidence of coordination.

For example, I think there are six or seven projects in the area of continuing education and the Continuing Education Committee of the Region has not met for the last year.

I think their CHP relationships, as far as I could make out, were reasonably good, although in one instance Comprehensive Health Planning responded with negative comments of a technical nature about one of their projects, and as I read the project description, I must say that I believe CHP was right.

And the Region did not take any note that I can see of the ideas coming from the Comprehensive Health Planning agency.

So I did not think there was any way this region could be considered above average, and I was -- in other times, you know, this Region would not have been an average region, and therefore, the 276 percent increase in funding did not seem very logical.

WHD-56

There were several things, many of which were brought to the attention of the Staff, on these yellow sheets here. You notice there are now eight full-time professionals on the staff, and it is proposed they hire an additional 15 people in the next year to a program which will presumably phase out at the end of that time, and although in the past there has been a close relationship to the Governor's Office in this state, nothing is made of that in the present application, and there is no reason for me to assume that those 15 people would have any kind of continuing employment, and unless the labor market is better in Wisconsin than it is in Detroit, they are in trouble, in trying to recruit that many people.

Nor am I certain that in the course of a year, even if they could find them, they could get them organized into a constructive program.

The Region has spent $1,400,000 on Emergency Medical Services, and -- or at least they were awarded $1,400,000 -- and I would assume they spent most of it, in the last -- they have $118,000 to run them to June of '74, and they are requesting essentially another million more.

The program is very well described. This particular project is very well described; they think, you know, the goals have been set up for some time and they are good goals, to show that there has been quite a bit of thinking.

But I guess we have the problem now, with independent

funding available elsewhere, whether it is appropriate for us to spend that much money in very direct -- you know, by buying telemetry equipment, in the direct development of the EMS system.

On the other hand -- well, I am not sure; it may be that there is adequate staff in that area, so this one thing they might do particularly well. I can say no more about that.

There are $430,000 in continuing education projects, plus $100,000 for a discharged-summary review for the hospitals in the state, so it is $530,000 in essence for that, and that in a place where the continuing education committee does not meet, and where there is no particular indication that, you know, it would be fine if they could say:

> "We are going to look at the discharge summaries and try to identify some things that continuing education is needed for."

But there is no suggestion of any melding of -the idea of quality review in continuing education that I can think of, or that I can find.

There are a couple of research projects that snuck in: development of sero-diagnostic procedures for gonorrhea and quantitative cytotoxic assays, and they are exciting projects. The cytotoxic assay, though, they didn't even bother to describe it as a part of the Regional program, so

there is another $100,000 that troubles me.

There is $156,000 in mental health programs, and I -- they are not such bad programs, actually -- are we allowed in that business?

MR. CHAMBLISS: That is an expressed concern of Staff, and we would certainly note your concern, because it does raise a substantive policy issue of funding.

Your question is very germane.

MR. VAN WINKLE: Those programs have traditionally been funded elsewhere.

DOCTOR CARPENTER: Well, you know, I suppose you can make a regionalization out of mental health as well as out of physical health, but we will leave that for the policy-makers.

I wonder if Staff would like to comment before I guess at a -- or before one of you all guess at a funding level?

MR. CHAMBLISS: Mr. Van Winkle, will you and Mrs. Parks?

MR. VAN WINKLE: I want to say one thing about EMS.

This was a proposal that had been submitted to us, to a select EMS Special Review Committee; it was approved for three years, and received two-year funding direct from here, in addition to their normal operatig - funds.

The reason we flagged it was not that it was any-

VHD-59

thing new; it is a continuation, but we flagged it because -- what did they get on their first award?

MRS. PARKS: I think it was about $1.6 million or something, for a two-year period.

MR. VAN WINKLE: They are asking almost as much for the third year as they had for the full two years, and that seemed like a tremendous increase in funds to us. It looks like a doubling up in the last year.

MRS. PARKS: Well, this is why it was flagged, simply because it was a tremendous increase over what they have gotten.

DOCTOR CARPENTER: What do you know about the management system for the use of those funds? Is it these eight staff people, or do they have now a group of people who are established --

MR. VAN WINKLE: They are well-established, and Mike, from the Mid-Continent Branch, has visited that program, on an EMS basis, and I think the concurrence is that this is probably one of the better EMS programs that they have run into in the country.

MR. POSTA: Of all the supplemental funds that RMH put out -- we did visit 23 projects this past year, and they were without a doubt the top program.

MR. VAN WINKLE: But our question was -- the reason we brought it to you is that that seemed like a tremendous

jump in funds, because that is about what they had for a two-year period, and now they are asking for almost that for the third year.

MR. CHAMBLISS: I would like the Committee to know that we are asking for your judgment here as to -- and your recommendations about the funding.

DOCTOR SLATER: Well, just a minor one, because it is such a small amount of money. Mrs. Salazar and I were consulting, wondering whether that Self-Administered Sex Therapy Program is -- violates the Federal guidelines for RMP's.

MR. CHAMBLISS: That is certainly one of the policy matters we will be handling.

MR. VAN WINKLE: We could not particularly tie that back in to their goals and objectives.

MR. THOMPSON: Who got the book?

MR. CHAMBLISS: That has been noted with great interest; that will be taken into consideration.

MR. THOMPSON: Who is the Principal Investigator?

MR. VAN WINKLE: Doctor Carpenter, I would like to add one thing.

We have Staff concerns here about the leadership of the program. I think you should know they quite recently came in for some rebudgeting of some dollars they had, and up to this point in time I don't believe we have approved that.

HD-61

MRS. PARKS: We have not gotten the additional information.

MR. VAN WINKLE: We have told them to go back home and further justify the information that would even allow them to rebudget.

So we are concerned, and we think we have tried to express this.

MRS. PARKS: During the phase-out, Doctor Carpenter, they did lose just about all of their key professionals on their staff, and of course, as you mentioned, Doctor Hersbeck finally left, too.

At one point they were down to just about no one except the present Coordinator, and the management aspects of the program -- there was actually no one there at one point to handle the program.

They have hired accountants now, and though while it is kind of early to really evaluate his effectiveness, he seems to be getting in there and trying to get some of the problems straightened out.

MR. VAN WINKLE: He is one of the positive things we see.

MRS. PARKS: Right. And the request for additional staff -- frankly, I can not justify it because I am not clear on what all of these people will ultimately do and it just seems awfully ambitious to me.

DOCTOR SLATER: It sounds to me as if the judgment is going to have to be made substantively, rather than in any specific objective grounds that you have.

What I hear is that we don't now know how the staff will be used, and we are uncertain what -- whether or not they can really float that much by way of programming if they have the money.

I am talking about making a recommendation of $2 million. They are at $1.73 now; that leave about another $500,000 to come back in for in July to get up to the 100 percent.

The 276 percent is just out of the question.

DOCTOR CARPENTER: Is that a motion?

DOCTOR SLATER: I am just asking if that is a sort of ballpark -- if we are both together.

DOCTOR CARPENTER: I couldn't decide between $1.70 and $2.0.

MR. CHAMBLISS: The Chair will entertain a motion here as to the level of funding recommendation.

DOCTOR MILLER: Could I ask a question first?

MR. CHAMBLISS: Yes, Doctor Miller.

DOCTOR MILLER: Is it true, and to what extent is it true, that the current level of annualized funding, as you have listed here, in most cases probably is the level that was the highest that Region ever had in the history of the Region?

WHD-63

MR. CHAMBLISS: Is that the case?

MR. PULLEN: Yes, sir.

DOCTOR MILLER: I think most of these are just about the top that the Regional Medical Program has ever had.

MR. PULLEN: I think it was more the 779.

MR. CHAMBLISS: Nonetheless, in this Region, if you add to it the Emergency Medical activity, you would find it a substantively higher level of funding of Regional program activities; I think this is about the level.

DOCTOR CARPENTER: Do you have an expenditure report for the July meeting?

What am I asking for? That would be too early, I guess? Yes; sorry.

DOCTOR SLATER: Recommendation for two million dollars?

DOCTOR CARPENTER: Yes.

MR. CHAMBLISS: I am advised by Mr. Pullen, of our Grants Management Staff, that the expenditure reports were due May 1st, and they are in the process. They are being processed now, so the answer is yes, we will have an expenditure report by July.

DOCTOR CARPENTER: If they are expending at the rate they say they are, in July, or as they say they might be, and we want to push the Emergency Medical Program at that time, we

:WHD-64

would have another opportunity, or if we wanted to take the lid off, then I would second what I understand to be a motion for two million dollars.

DOCTOR SLATER: Two million dollars.

MRS. PARKS: Two million?

MR. CHAMBLISS: The motion has been properly moved and seconded that:

"The level of funding to be recommended for the Wisconsin Regional Medical Program be set at two million dollars."

Is there further discussion?

Are you ready for the question?

DOCTOR CARPENTER: Yes, can I add a little, or at least think about adding something to the record?

In view of the problem of whether they can effectively use that money for the Emergency Medical Service, would it be practical to ask them for an interim funding report? This one here will only carry them into '73. I guess that would be July of '73, so if we could have a few months more information, I think it might help them.

MR. CHAMBLISS: Yes, we can request that, and Staff will do that.

Is there further discussion?

Call the question; all those in favor?

(Chorus of "Aye")

VHD-65

Opposed?

(No response)

The motion is carried.

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MR. CHAMBLISS: I would like now to turn your attention to the Kansas Regional Medical Program.

The presenters for Kansas will be Mrs. Wyckoff and Doctor Vaun, and Staff support will be in the person of Miss Mary Murphy.

REGIONAL MEDICAL PROGRAM REVIEW

KANSAS

MRS. WYCKOFF: This is a modest request from Kansas. I am going to follow your design that you have in the Review Sheet, and try to construct my report along those lines.

Program Leadership: the Coordinator, Doctor Brown, has been with the Kansas RMP for several years and knows how to work with the Kansas state and local organizations.

He understands the nature of Kansas and has its support. He has bent over backwards to get provider support in the early days, and has never fully recovered from that effort.

He has a good working RAG, which has met regularly every month. His Executive Committee functions regularly, as does his project review committee. They have good EMC representation.

The program staff. During the cut-back the staff was reduced, and if you will look at the little yellow sheet here you will see that he has, really, a very small staff of nine professionals, two clerical.

MR. CHAMBLISS: If you would kindly talk just a bit louder, please?

MRS. WYCKOFF: The remaining staff are skilled, having a minimum of 16 months RMP service. They have had to do dobule duty in project development and monitoring.

VHD-67

The Health Service education directors have helped to fill the vacuum created by the loss of coordinators. There is a close and cooperative effort work with the CHP.

There are no minority members on the staff as far as I can tell.

The RAG. The RAG has about three or four consumers among 22 persons, and appears to have only one minority member, though there are a very few on some of the subcommittees.

The RAG is hard-working and dedicated, and has an Executive Committee that keeps things moving in between Council meetings. Its Project Review Committee screens and evaluates and recommends all projects to the Council, and the Evaluation Committee monitors the projects.

The RAG shows itself capable of acting well under the stress of the present application. It has a liaison subcommittee relating to CHP.

However, this report is probably the most confused report that I have ever read, and if I seem confused, it is because I have been mired in it, trying to find what it is he's trying to say. So you will have to excuse the jerks when we jump back and forth between subjects.

I will stick, however, to the design we have here.

The past performance has addressed substantive problems, in accessibility and availability, both in rural and urban ghetto areas. For example, under "Access," they have

the Model Cities Program, which of course was closed down by other factors than RMP.

The Ottawa County health clinics, the Dart City Indian Health Care Clinic, DeSoto Rural Health Clinic, Kansas City Rural Clinic; under their efforts toward efficiency and quality in professional performance, they have improved the Kansas Library Information system.

They have a rural circuit course for nurses that has been effective.

These are examples of what they have had; the cadre training for pharmacists, and under "New Skills" they have had several courses for clinical nursing and dental systems.

Under their "Past Efforts at Regionalization," they have their Great Bend project. I had great pleasure in making a site visit to that once, and it is quite an experience, I assure you, puddle-jumping across those fields in a tiny little four-seater plane with Doctor Nicholas.

I realize how thoroughly rural a lot of Kansas is.

They had an extended coronary care unit, like most of the RMP's of that day, and nephrology training. They have been working to set up the -- the core staff has been working to set up four big health education service centers, and they are now coming in for a substantial amount of money for these.

They have helped with other Federal programs; they

have been called upon to help with the Emergency Medical Service, and they have successfully launched the big kidney program which is quite well known throughout the center of the country.

The measure of their work, I think, is seen by the fact that the major -- the 18 major programs that have been terminated have been continued with local support or with other support.

Their Circuit-Nursing Course, their Physician Placement program, their Kansas Library project, the Nurse-Clinician project, the basic education for medical clerks, and the formal regionalization of the kidney program, and method of treatment.

Under Point No. 5, "Objectives and Priorities," they say their objectives have shifted from the emphasis on the information gap to direct concerns for the expansion of new services, Region-wide projects, or categorical disease and quality assurance.

Much work has gone into sub-regional area development of these manpower services, area education programs including public education.

They have had varying degrees of success in carrying out their short-term objectives in the following fields:

Health-care delivery, primary care:

1. More effective health manpower;

VHD-70

2. Quality medical care assurance.

3. Disease control.

And it is not until you get under "Disease Control" that they mention anything to do with planning.

The new proposal falls into place as congruent with the major thrusts listed above.

The 13 projects for which they asked continuation funds are in line with their program objectives, and they have been carefully and favorably reviewed by CHP.

Four new projects are as follows:

Quality assurance of diabetic care: $28,500. They proposed to develop a model management system, protocols for the health-care team, education, assessments of patients, projects in training and utilization of the diabetic nurse-practitioner, the CHP --

The CHP comments:

"The issue of funding beyond the first year is not addressed, and efforts to obtain patient input and acceptance are not described. However, the major outcome expected appears to be in standards for use in peer review and in professional education systems at KUMC."

This will supplement the juvenile diabetes project now under way in Wichita, and sponsored by the Kansas Diabetes Association. These fit under their Objective 3 above: quality

improvement.

The second one, the second new project that they are asking for is primary health care in DeSoto, a small rural community -- $26,288.

The rural community has raised $4,000 in this rural county of a population of about $7,000 for a primary care clinic sponsored by the Cedar Valley Medical Association. It is now operating with a nurse-practitioner and a part-time physician.

CHP okays the project but raises the question about the development of criteria for disposing of grant-related income. This is one of their rural access objectives.

The third one is the Berkley Health Education project, which as I guess you know, is a 6th and 7th grade public education program -- a campaign against smoking.

The fourth one, the perinatal mortality project regionalization, is for $305,000 and it is a very elaborate project, and they admit that this will take at least five years before this can become operational.

The RAG says that this has special merit, and I question very seriously how we are to interpret the term "feasibility" when they say that with five years -- that five years is the limit that they need.

Now, with CHP relationships, I would say they are very good, although they have not been funding CHP activities

WHD-72

as much as some of the other RMP's.

I notice on the Staff summary that the concerns here -- No. 1, Project 70-A, Emergency Medical Training, Extension of Project 70 -- was initiated from program staff funds and is a continuation of the activity.

This seems a legitimate enough program, if we are permitted to fund this sort of thing.

The second, Project No. 51, where the funds went from $24,000 -- or $48,000 in one year to $117,000 in one year, is a pretty big jump, and Project No. 52, which has gone from $40,000 to $112,000 is also a pretty big jump.

But from the little I am able to find in material, it seems as though they have been preparing to expand, and that they possibly can do this effectively with the increased funds, since they have built a network at the junior colleges, and they have laid the groundwork for the health services education work.

The one I raise the question about, however, is the $305,000 perinatal project, and I would like to hear from Doctor Vaun about it.

MR. CHAMBLISS: Will you continue, Doctor Vaun?

DOCTOR VAUN: I think the Director comes through as a very strong and good leader for the project. I am impressed with him, I am impressed with the continuity of RAG at a very difficult time; I am impressed with the shift of object-

ID-73

ives, and more so with the addressing of projects to the rather mundane, everyday needs of people, like dental attention, and diabetes, rather than tribioplastic tissues.

I am tremendously impressed with the scope of their projects relating to real health care needs.

I am further impressed with the continuation of fundings on projects that have been terminated. They have a good track record with that. I would hate to dock them anything, but as Mrs. Wyckoff has identified, I think they are overly ambitious in their perinatal projects, and I don't see coming through any special contribution on the part of the hospitals.

I think their faculty is terribly fat, with two part-time neonatologists; I didn't know there were that many in any one state, let alone that they were going to be faculty, and -- you know, again addressing themselves to the development of their own intramural audio-visual aids -- this just leaves me a little cold.

So I would recommend, subject to Mrs. Wyckoff's modification, a $100,000 reduction from their request. The request was $1,733,380; I would recommend $1,633,380.

I do it with tongue in cheek, because it would appear that these people came in with a very reasonable request. They didn't ask for the Moon, like some of the programs have, and I hate to dock them anything, in view of the

HD-74

fact that they are not even up to what target might be, but I think the project, as I said, is overly ambitious, does not address certain items that I think are terribly important.

So I think I am going to recommend that they be docked $100,000.

MR. VAN WINKLE: And do you want a message to get on that particular project?

DOCTOR VAUN: I think something should be said about it in light of what Mrs. Wyckoff commented about.

MRS. WYCKOFF: They are only asking for 77 percent of their target, and when they get -- if they get the whole $300,000 that they are asking for in July, they will only get 91 percent of their target.

So theirs is a very modest request, actually. I am sorry that they have put so many eggs in one basket.

DOCTOR SLATER: Question. If there are funds left over after these two rounds, is it possible for these Regions to come in again for further supplementary funding?

MR. CHAMBLISS: No, there will not be, Doctor Slater.

DOCTOR SLATER: This is the end of the line, even if there is money left over?

MR. CHAMBLISS: They will not have a new opportunity to apply. The July 1 application date is the final date as things stand at the moment.

WHD-75

MRS. WYCKOFF: I would like to ask about this indirect cost information that is in this project. It ranges from 55 percent down to 8 percent, and I wondered if -- if it is perinatal, what would affect this?

MR. CHAMBLISS: I wonder if our Grants Management man would speak to that? I do recall Kansas having perhaps one of the very low indirect cost rates, sometime ago.

MR. VAN WINKLE: This is different institutions, is it not?

MRS. WYCKOFF: Yes, it is their whole list.

MR. CHAMBLISS: Staff is checking that now.

MR. VAN WINKLE: It is just the varying rates, I would guess, between whatever institutions receiving the funds--

MRS. WYCKOFF: I hope we are talking about the right one.

MR. CHAMBLISS: I would simply ask one question of the reviewers. Are there any comments to be made with regard to CHP-RMP relationships in this Region?

MR. VAUN: I think Mrs. Wyckoff mentioned that. From the report they appeared good.

MRS. WYCKOFF: Yes, their relationships are good. I do think they need a little prodding on the affirmative action program.

They have a very small staff, but I think they

HD-76

should pay attention to it on their Board -- on their RAG.

So, with that as a suggestion, I would like to move approval of the --

DOCTOR VAUN: $100,000 reduction in their request.

MR. CHAMBLISS: Is that in the form of a motion?

MRS. WYCKOFF: $100,000.

DOCTOR VAUN: $1,633,380.00.

MR. CHAMBLISS: All right; that is a motion, I take it? Has it been seconded?

DOCTOR VAUN: I will second it for Mrs. Wyckoff.

MR. CHAMBLISS: It has been moved and seconded; is there discussion?

MISS MURPHY: I would like to make an addition.

MR. CHAMBLISS: We would like to have further input from the Staff. Miss Murphy?

MISS MURPHY: I would like to add that they did have a minority professional on the staff, and with the phase-out she left them. I think that is probably what has actually happened in a lot of areas.

DOCTOR MILLER: In response to a question by Doctor Slater, it is fair to say -- to tell the Committee that the RMP-DRMP staff does intend to award all the funds that are available, if the Review Committees approve that much and the National Council approves it.

MR. CHAMBLISS: Yes, they do indeed.

WHD-77

DOCTOR MILLER: The intent is to award all the money requested now -- between now and the next period.

MR. CHAMBLISS: If it is properly reviewed and recommended, yes, we will.

DOCTOR SLATER: Well, the question came up- this morning, on whether we might like to recommend withholding, rather than give it away to the programs.

DOCTOR MILLER: We might, but if we do it will just be on expended funds; it will not be awarded any other way.

MR. CHAMBLISS: All those in favor of the motion?

(Chorus of "Aye").

Those opposed?

The "Aye's" have it, the motion is carried, with a recommended level at $1,633,380.

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MR. CHAMBLISS: Shall we now draw our attention to reviewing the application from the Michigan Regional Medical Program?

MR. TOOMEY: Did you rule on this Inter-Mountain?

MR. CHAMBLISS: The Inter-Mountain Region will be reviewed in lieu of Wisconsin in our final session. That is how we got Wisconsin early on, and Iowa was also one that we were holding over, and I thought I would review them in that order, until Doctor White returns.

MR. TOOMEY: Unless there are other reasons, I am here, Mrs. Salazar is here and Miss Murphy is here; why don't you get rid of Inter-Mountain?

MR. CHAMBLISS: All right. All the parties are here, and Inter-Mountain will be presented by Mr. Toomey and Mrs. Salazar, with Miss Murphy as the Staff person.

REGIONAL MEDICAL PROGRAM REVIEW

INTER-MOUNTAIN REGION

MR. TOOMEY: Once again, back several years ago, I had the opportunity to visit the Inter-Mountain Medical Program prior to awards, prior to Doctor Stuart's becoming Coordinator. I think it was Mr. Hagman who was the Coordinator back then when I visited.

The implication, in my opinion --

DOCTOR SLATER: Would you speak up, sir?

MR. TOOMEY: Program leadership is satisfactory, from all appearances. I have not met Doctor Stuart, but I understand that he is rather a contrast to the former program coordinator.

The former program coordinator had some difficulties with the administration of the University of Utah, and apparently from the material in the application, Doctor Stuart has been able to overcome those problems, and their relationships were on a very satisfactory basis.

The program staff seems adequate in size; their capability seems to be sufficient. When I was there a year and a half -- two years ago, they had some trouble with the evaluation program and apparently that program still exists, because one of the positions are still vacant, and the Deputy Director of the program is in charge of the evaluation at the moment.

IHD-80

Their Regional Advisory Group, as far as I see, both in the application and from my personal contact, is sather outstanding. They are interested, they meet regularly; as a matter of fact, they had five meetings that were listed over the past year. Their Executive Committee meets -- has met at least three times.

The past performance and accomplishments of the Inter-Mountain RMP seem to be adequate. Their relationship with the Comprehensive Health Planning agency in the area they cover, which incidentally covers Utah, Montana -- or parts of Montana, Colorado, Wyoming and Nevada, and they have programs that have been extended into each of these areas.

They have established as their objectives and priorities programs related to rural health care needs, to strengthen -- the strengthening of the local health planning, to quality assurance -- projects related to quality assurance in primary health care, and the Emergency Medical Services.

Their proposals seem to conform at the present to these major thrusts that I just mentioned.

I think however, that it is important to note that there are 11 programs for which they are requesting continuation funding, and that there are 38 new programs for which -- that they are proposing in this present application.

HD-81

Because of the 11 and 38 -- that's 49 projects -- it seems as though they have in fact bitten off rather much to do, and because of this they have requested considerable sums of money, and if you will look at line 15, the Inter-Mountain section, their current level of spending, annualized, is $1,878,000. Their targeted available funds are $3,597,000.

Their May 1 request is for $3,849,000, which is 106 percent of the targeted available funds, and the total of the July 1 estimate is another half-million dollars, which would bring them up to $4,349,000, or 120 percent of the targeted available funds.

In terms of the yellow sheet that you have in your booklet, there is -- the very last line, I believe, the Inter-Mountain Regional Medical Program is considered a good program, but it is felt that the Region is over-funded.

I might say I heard this from several sources, from people who have been acquainted with the program, but I have to say, in defense of what has been done, that it has been a very aggressive, a very viable, a very concerned program, and it would seem to me that on the record of their past accomplishments, they would probably rate as certainly a good to excellent program.

I would agree, on this premise, that they should perhaps have a greater consideration given to the amount of money that they are requesting, more on the basis of the fact

VHD=82

that they are requesting three -- and almost four times as many programs -- to be put into operation as what they currently have in operation, and from that basis it would seem to me questionable as to whether the total amount of dollars should be provided.

They have done one other thing, apparently within the past year, the implications of which I am really unable to evaluate at the moment, but because of the interest in RAG and apparently because of the extreme -- what I would consider to be their concern that they continue with an on-going operation, to pick up the main threads of an RMP program and develop a new organization called the "Health Development Services Corporation," and this was not in existence when I was in Salt Lake City, previously.

I did not have the opportunity to talk with the staff about this, but it seemed, from very quickly reading this paper, which is an attachment in your booklet, that it seems they have created an organization structure which would allow for the work of the Regional Medical Program to be carried on, to secure funding from numbers of sources, and to provide for -- really through the sale of their services, to provide for the continued development of many of the needed programs in those areas.

This sort of Health Development and Services Corporation, which is a separate organization, has come back,

now, to IRMP and requested funds for some of the projects that IRMP has approved in the amount of almost $405,000.

So IRMP will be funding an organization which was created by IRMP to pick up the threads of the work of Regional Medical Programs in carrying it on, and it is a voluntary non-profit organization, and I don't mean then at all to imply that there is a thing wrong with it. I just think it is a very in novative and aggressive kind of move on the part of the people in that area to provide for themselves a mechanism to continue their work.

The other thing to which I would call your attention is the extent to which IRMP is -- and you will find this, again, in your yellow sheets -- they are providing assistance to the Idaho Comprehensive Health Planning agency, the Utah agency, the Montana agency, the Western Colorado A agency, comprehensive health planning, and in Nevada the Comprehensive Health Planning A agency, so that these planning agencies in the state, which make up a part of the Inter-Mountain section, are being specifically funded out of the RMP funds, and I haven't added it up but it makes rather a substantial sum of money.

In addition to which they have a number of projects related to the development of influence in the hospitals to act, I presume, in a more efficient and effective manner. Management consulting services, management engineering, and

WHD-s84

multi-hospital in-service training, and several others.

I would just comment in general on the fact that personally I am not sure that it is the responsibility of the Regional Medical Programs to specifically focus on the development of the hospitals to enhance their capabilities from a management standpoint. This is the question that I do have.

I don't have any question about their support that the A agencies, particularfy in fact -- in light of the fact that it is one of the areas in which the IRMP says they are interest, to strengthen local health planning.

I don't know whether strengthening the A agency can be construed as local health planning, but I -- attempting to give consideration to planning needs in that area.

In net, when I look at the record they have, when I have the remembrance of my visit with the group in Salt Lake City -- their leadership, particularly, from the Regional Advisory Group, and the fact that their objectives and their priorities are in line with those that they have selected -- or, let me put it this way: their project is pretty much in line with their objectives and priorities that they have selected, and it seems to me that we have a good to excellent Regional Medical Program which shows good strength, innovative ability, a desire to continue the work, to enhance the planning, to provide for better services in the area, and it

is only that I have some doubts as to some of the projects.

That is one facet, and I have some doubts as to the capabilities to initiate, desirably, 38 new projects, so that I would change the recommendation -- change the funding that they have requested, and I don't -- now, Mrs. Salazar, you want me to say what I think it should be, the neighborhood in which I think that funding should be?

MRS. SALAZAR: Yes.

MR. TOOMEY: I think it should be reduced somewhere in the neighborhood of two and a half million dollars, as opposed to the request they have, which is $3.8 million.

MR. CHAMBLISS: All right. Will -- Mrs. Salazar, will you make your presentation?

MRS. SALAZAR: I have nothing to add. Some of the concerns that I have had about the application have been explained by Mr. Toomey, who has been in the Region since I have. His last visit pre-dates my numerous visits.

I do have one question that perhaps Staff could address themselves to, which deals with the Region's past history and mechanization, dealing with hardware.

That was one of the old problems that we used to discuss.

Secondly, in reading the last site visit report, which took place in January, I believe, of this year, there were some very serious issues raised as to minority groups

participating in RAG's or Executive Committee, and staff. And this, too, is an old program that has been with us for a long time.

MR. TOOMEY: I did not have time to read Mary's report on the last site visit.

MRS. SALAZAR: The third thing that I might ask is what will be the interface to assure that there will not be duplication of funds going into the new corporation and into the Inter-Mountain Region Medical Program? How do they co-ordinate the efforts? Are they two free-standing, and how do they relate?

MR. CHAMBLISS: If you raise a question about the corporation, I think the Committee might be interested in something of a report that our Grants Management branch has developed on the corporation, and I would ask Mr. Pullen if he would express those concerns to the Committee, please?

MR. PULLEN: These are some of the concerns expressed by the Grants Management Branch about the Health Services -- Health Development and Services proposed by the Inter-Mountain RMP.

It does not appear to have the final approval of the grantee to organize a staff. Such a corporation, with RMP employees. We are not aware of the use of RMP employees solely to staff an affiliated organization, as proposed, and we seriously question the proposal of the corporation as being

VHD-87

necessary to fulfill IRMP requirements. The proposal appears to be broader in program and geographic scope than the RMP.

Since it exceeds that of the IRMP-BMS Alaska Project, I do not think it is appropriate for the developmental costs through employee support to be charged totally to the grant.

As previously advised, the RMP does not charge any organizational costs for this corporation to the grant funds. It is understood that this organization is designed to assume all of the normal functions of the RMP program staff after termination of grant support.

If the corporation is determined to be a free-standing organization, then the incorporating costs should be spread among the various supporting agencies, not solely to the IRMP.

A statement from the grantee will be required to indicate that the development of such an organization with its grant funds is in keeping with the grantee policy, particularly considering the broad scope proposed.

This proposal would seem to be a mechanism to bypass the changing of an RMP from a university to a free-standing organization which the coordinators have been discouraged from finalizing prior to passage of legislation.

It could well be that if we are able to approve this technique, other RMP's may elect to go the same route with grant funds in anticipation of passage of new legislation.

D-88

MR. CHAMBLISS: I think that may answer some of your questions. It does express some concern emanating from the Staff regarding the corporation.

We admit that it does have innovative features, but whether there is a bit of prematurity here at the moment will be left for your judgment.

Mr. Posta would add further comments.

MR. TOOMEY: I don't know enough about it, becuase you know, I didn't get a chance to read this until just this morning.

MR. POSTA: This, I might say, Mr. Toomey, is relatively new as far as the other administrative problem issue that we have had to do business with for the last two weeks.

First of all, we have heard from the Region, too, which -- which assures us that this is a separate entity, as of July 1, the same as the Health Department or AID or any other institution. I think our concern as far as IRMP is concerned is how much RMP or grant funds have gone into this particular corporation since its birth in January of this year, through a charter with the Secretary of State of Utah.

The grantee has worked with the Attorney General; they do not think there is any hanky-panky going on. The grantee has written a letter to the RMP giving their views

WHD-89

on this particular corporation, and they definitely will dichotomize those costs going to the RMP and to this particular corporation, which to date have amounted to about $18,000. That is the latest on the corporation as of this morning. We just got this $18,000 figure this morning.

MRS. WYCKOFF: How do they from the Health-Set corporations that have been formed all over the country that are non-profit and separate and funded by RMP?

MR. POSTA: I wish I could tell you; I can't.

I do know that our original -- I should say from the Mid-Continent operations concern all along has been: who are on the Board of Directors?

Are these folks a part of the IRMP? And if they are, this might be a conflict of interest, and they would have to make this decision.

This is what we are still working on, but I think it is a legal corporation the same as any other corporation asking for a charter in most of your states.

MR. TOOMEY: As I understand it, there is an overlapping of the Board membership between RAG and the Board of the Health Services Development Corporation, and there are employees of IRMP who are on the Board of this new corporation, employees.

MR. POSTA: Well, the Coordinator, possibly -- or probably.

ID-90

MR. TOOMEY: Well, in there it said there would be minority representation from the employees.

But the other thing it seems it is going to do is to essentially really act as a broker. It will go out and develop programs and then it will come back and attempt to convince IRMP to fund those programs; am I not right?

Between the money that is going through that organization and the fact that there are 38 new applications, and there are questions about a number of them, I felt that two and a half million which is, I believe -- they are annualized now, out of that $1,800,000, so this represents an increase over their annualization, but it is a million-three under what they are requesting.

MR. CHAMBLISS: Yes.

The first presenter, Mr. Toomey, came up with a recommendation, but as I recall, that has not been placed in the form of a motion.

MRS. SALAZAR: I would be glad to second, but I prefer to withhold a second until I hear some other comments on the other points that I raised.

MR. TOOMEY: You see, the point -- I think the thing that worries both of us right now is the fact that so many people -- well, a number -- two or three people -- have made the comment:

"This is an organization which already had

already had a million-eight and seems to be overfunded," and so now they come back in and their request just about doubles that, and you reduce it by a million-three and I think the question still is: is it overfunded, and I don't know how to answer that.

MRS. WYCKOFF: Are any of these project numbers money that goes into this organization? We can't tell from this which ones they are.

MRS. SALAZAR: Some project staff will be functioning in this new organization, as I understand it on page 14, but they would gradually phase out as this thing becomes a free-standing agency.

But this is the part that bothers me, as to who is looking at that during that interim period when IRMP is overlapping this organization.

MR. POSTA: As I understood that document, the Executive Committee of the Regional Advisory Group is the watchdog organization of this new corporation.

So far as Mr. Toomey has mentioned, $18,000 --

MR. TOOMEY: And the projects that they talk about, the ones that are meaningful -- medical consultation for rural communities, that's a 99; rural medical technology systems, medical consultations, $40,000. Rural medical technology systems, which is Number 104, is for $115,000.

Rural quality assurance, No. 105, is for $126,000.

And rural medical practice and management, $114,000. That is No. 106.

The other one is modeling the Utah Health Care system, which is only $7,100.

That is a level of about two and a half million; why don't I cut that back to two?

I move that we allocate two million dollars to the Inter-Mountain Region Medical Program.

MR. CHAMBLISS: There is a motion on the floor that the Inter-Mountain Regional Medical Program be set ata level of two million dollars.

Is there a second?

MRS. SALAZAR: This is across the board, Mr. Toomey, that you are talking about?

MRS. WYCKOFF: Now they are at one million-eight, so this -- it raises them $200,000.

DOCTOR MILLER: They are at $1.88 million.

DOCTOR SLATER: $200,000 instead of two million.

DOCTOR MILLER: It raises them $120,000, so you essentially are holding them to the same level of current funding.

MR. CHAMBLISS: Is there a second on the motion?

DOCTOR VAUN: I have a question, but I don't have a second.

HD-93

MR. CHAMBLISS: All right; maybe the motion will die for want of a second.

MR. THOMPSON: I will second the motion, just to get it on.

MR. CHAMBLISS: The motion has been made and seconded that the:

"That the level of funding for Inter-Mountain Region be set at two million dollars."

Is there discussion? Doctor Vaun?

DOCTOR VAUN: I still have not heard an answer to Mrs. Salazar's question. All I have is hearsay that they are over-funded. I mean, does anybody have any evidence that they have a Swiss bank account or that their projects are lousy? One or the other?

Otherwise, this is hearsay and I don't think we should use that to really cut the program fairly substantial amounts of money. Their performance has been good, I think; that is what we have to go on, and not the hearsay that they are overfunded.

MR. POSTA: Doctor Vaun, could I respond to that, please?

DOCTOR VAUN: Somebody had better, I think.

MR. POSTA: I think that the Council took a fall site visit to Inter-Mountain this last go-round, and was concerned primarily because of the turf problems that existed

VHD-94

in Mountain States Regional Medical Programs, the Inter-Mountain Regional Medical Programs, and Colorado-Wyoming, and I wanted to be careful not to say that this problem is -- has been solely Inter-Mountain's.

But Inter-Mountain has had more turf problems that -- than all Regions in the country put together. They are even in Alaska now, doing an EMS project.

But that is to their -- you can pat them on the back with one hand, but other people, particularly Mountain States -- Colorado-Wyoming and the like, don't particularly care for-it.

So I think that what I am saying is as straightforward as possible, that there are some people that feel that this Region has got too much money and they are getting in everybody's way in the surrounding territories.

Now, what we did demand in this particular application is to have the inter-Regional Coordinators group, which is composed of the three Coordinators of those three RMP's, together with the coordinators, get together and take a look at everything that has been accomplished, and everything that is requested, and everything contemplated on being rebudgeted -- they actually met on May 9th and have submitted a letter signed off by six people, that all but ten activities have been approved by all three Coordinators and RAG Chairmen.

They will meet again, and have mentioned two dates

ID-;95

that they will be meeting together final dollars will be distributed among the three Regional Medical Programs.

But I think, to zero in, Jesse, on your question concerning why do we think this is overfunding, it is coming from several different discussions with your group.

MR. THOMPSON: Well, if you have hard evidence -- you know, when they say Inter-Mountain -- that's between any two mountains you can find.

MR. TOOMEY: You take a look at the support of the Nevada A agency, and I think they have only touched a little bit of Nevada, and here they are funding A agents for the whole darned state.

MRS. WYCKOFF: I just don't understand the policy of funding A agencies and then turning around and asking for their approval. There is something corrupt about that. They wouldn't dare not approve.

MR. CHAMBLISS: Is there any further discussion? Miss Murphy, I think Jesse had a question about the minorities, and we have always brought that up, and it seems every time we get a few on the staff --

MISS MURPHY: Then the phase-out came, and we lost several Orientals, but the day after our site visit, the Great White Father brought some Indian into the Inter-Mountain Regional Program from the Arizona area, and they hired him on the spot.

So they hired him on the spot, and he is responsible for all the Indian components that are in the projects. But they still insist that they have their quota of minority compared to the number of minorities in the Inter-Mountain Region.

About hardware, I went through rapidly; I counted about $173,000 for all the projects. I don't have anything else to compare to.

MRS. WYCKOFF: Are there RMP projects where we are assisting the state legislatures with information on an organized basis?

MR. CHAMBLISS: That is a policy issue; we have discouraged this before, Mrs. Wyckoff. We have discouraged this before, in this Region, I might add.

MRS. WYCKOFF: There is a great increase in the amount of money for that, too.

MISS MURPHY: We discussed that at the site visit and CHP had asked for that program, and their concern in the comments was that they had not elicited the people that would attend, so they had turned the program, the seminar, completely over to CHP, and I think it was 110 or one of those Regions, and they are going to run it.

They are going to select the people right up there themselves.

MR. CHAMBLISS: It simply still has some connotations

though, that we might question, especially in dealing with the legislature.

MR. THOMPSON: Your primary purpose is to set up HMO's; to find out if the state legislature prevents community sponsored practices, then you have to go to the state to carry out your main objective.

MR. CHAMBLISS: We would agree there, but the question is, who should do it?

MR. THOMPSON: RMP.

MISS MURPHY: RMP is the only one with the money; the CHP doesn't have the money.

DOCTOR MILLER: Maybe I missed something here, but perhaps somebody could go over it again.

What is the purpose of this new organization? Was this new corporation formed to replace RMP when it finally dies out, or to be the future coordinator of CHP-RMP, Hill-Burton and so forth, if that evolves? Or is it a foundation-PSRO approach, or -- I didn't quite get what the purpose of it is.

MR. CHAMBLISS: Would you enlighten the Committee on that?

MISS MURPHY: I think possibly it is your certain -- your second comment. I think they will be ahead as far as the unified health plan is concerned.

DOCTOR MILLER: Do they have some articles of

incorporation or by-laws that would really tell what they are supposed to do?

MISS MURPHY: We don't have the by-laws, but they are incorporated, and there is the whole document.

DOCTOR MILLER: One of the things you are telling us from the Staff standpoint is that one of the things you ought to figure out is how they are going to react to the future legislation, which has not yet been written, which is a favorite story of yours, and in the past, too, I think.

But anyway, how do you put all these programs together at the local level? If that is what this is, we ought to give them a bonus instead of cutting down their funds. Because that is one of the goals.

MISS MURPHY: When they formed this corporation, they did it with the understanding they could go to places like Robert Wood Johnson and try to get funding that they could not get through the University, because it is a state university, because that is part of the psychology.

MRS. SALAZAR: I guess one of the problems that I have with this is the fact that they did not move away from the university immediately.

MISS MURPHY: This is my complaint. They want the best of both worlds.

DOCTOR SLATER: The new organization is tied to the university, too?

D-99

MR. CHAMBLISS: Does this discussion, Mrs. Salazar, begin to clear up some of your questions regarding the corporation?

Shall I call for the question?

DOCTOR MC PHEDRAN: Before you do, I would like to ask Mrs. Salazar, now do you agree with Mr. Toomey's funding recommendation?

MR. CHAMBLISS: All right; and Mr. Toomey's recommendation is that the Region be funded at a level of two million dollars.

MR. VAN WINKLE: That has been seconded.

MR. CHAMBLISS: That has been seconded. Those in favor, may I have the usual sign?

(Chorus of "Aye")

Those opposed?

(No response.)

The "Aye's" have it.

Now, may I call, please, just a short break for the convenience of our Recorder? Just a couple of minutes, please.

(Whereupon a short recess was taken.)

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WHD-100

REGIONAL MEDICAL PROGRAM REFIEW

MICHIGAN REGION

MR. CHAMBLISS: We would like to resume, after a momentary break; we will begin with Michigan, and as we begin with Michigan, we would like the record to show that Doctor Carpenter has in fact absented himself while this Region is under review.

The presenters here, Mr. Toomey and Doctor White, supported by Mrs. Parks.

Will you proceed?

MR. TOOMEY: I am of the opinion that the Michigan program was -- I am not of the opinion; I know -- it was difficult to read, difficult to understand, and I have feelings of inadequacy in talking very much about it, because I think that the proposal has a number of inadequacies.

Program leadership was difficult to determine for the kind and quality of program leadership; as a matter of fact, I am not even sure at the present time who is the program coordinator.

In a listing of staff, it listed Doctor Tupper, and in all of the signatures it had Doctor Graham-Welk as the individual, and so I have some concern -- not concern, but I just don't know.

The program staff; they have 12 people, four clerical, five professional and three in management.

WHD-101

The question you had on the review shseet is the adequacy of the program staff to manage and monitor the operation of projects, undertake such activities as will contribute to local CHP plan development and related efforts, and my one note here is that I found it difficult to find an answer to that question.

The Regional Advisory Group seems to meet only as needed, and it was difficult to determine their participation except on a project review Committee basis.

The question related to past performance and accomplishments; these items do not appear to be or have been consonant with the recent program thrusts, except for Emergency Medical Services, and more recently, today -- and this I did not know -- hypertension was encouraged because -- and a good thing it was, because the program is -- seems to have more than its share of hypertension projects in it.

Objectives and priorities at the present time relate to cancer, kidney, Emergency Services, hypertension, nursing homes, health manpower and development, and the proposal is, as written, it seems to me, to be questionable in terms of its appropriateness.

The funds they are requesting -- $3,777,000, of which $1,675,000, is a continuation project, and $1,755,000 for new projects; they have an estimated July request of $800,000, and Michigan's target figure is $2,000,000 -- their

HD-102

targeted available funds, is $2,969,000 -- approximately three million dollars, and their request at the moment would total, -as I said, $3,077,000 and when you add the $800,000 that they anticipate, it goes to better than four and a half million dollars, which is 154 percent of the targeted available funds.

I think there are problems related to the Emergency Medical Services; they are permanently requesting $750,000 increase in the funds for Emergency Medical Services, to provide a continuation of linkages and relationships between the Michigan RMP and the non-RMP programs.

I think overall, probably I would say that I was disappointed. I was disappointed in what seemed to be a lack of program leadership; I was disappointed in the information I could get out of it from the Regional Advisory Group. I had disappointments as I attempted to review the past performance and accomplishments and I felt they were not consonant with the objectives and the priorities, and I felt that their request for funds was very much out of line.

MR. CHAMBLISS: All right. Shall we turn to the second reviewer, Doctor White?

DOCTOR WHITE: I share Mr. Toomey's views, to some extent.

It was difficult to ferret out from this proposal who, if anyone, was leading the organization at the present

time.

As he mentioned, Doctor Tupper was indicated on -- in the narrative; in one of the budget pages it stated this was a TBA slot; either Doctor Tupper was being magnanimous and loaning his services, or there was indeed a lack of an executive director.

They have a bit of a confusing , relationship, in that they have what they call an Executive Director who is -- whose responsibilities are the overall direction of the program, and then they have a Program Coordinator, which I feel fills the more traditional role of the RMP Director.

I am not quite sure that both are necessary, but on the other hand, I seem to recall that Michigan got good grades in the past. It was a fairly well-regarded Region at one time, at least, and I don't know what has happened in this transition, but obviously there is some question as to whether or not leadership is adequate, at the present time.

And also, I share Mr. Toomey's concern as to whether or not the Regional Advisory Group, although it has continued to meet quarterly at full strength, has participated at the same degree of enthusiasm and the same critical attitude as it has in the past.

It does state, however, that the Regional Advisory Group is meeting; the members of it meet with the Comprehensive Health Planning and Hill-Burton personnel to develop health

ID-104

services resource, and I raise the question again, as Doctor Miller did a moment or so ago: is this an appropriate thing? Are these people something which will come to naught by virtue of the fact that they can't get the Congress to do it anyway?

They do seem to have appropriate Regional Advisory Group representatives on Review and other Committees, and on paper, at least, it would indicate that they have a good, thorough review process. I question that for something that I will bring up later.

Their past performance I did not evaluate well; I could not tell exactly from their narrative how many of these have been picked up by others and how many were continuing.

Some of them seemed relevant, and I based that assumption on the fact that they were previously given evaluations of good management and good hypothesis; therefore, one would assume that their continuing projects, having been approved under the old set-up were reasonable ones.

Their new ones, however, raised the question in my mind as to whether people haven't been too critical. They have something like 40 projects, in one guise or another, and I don't really get the idea from reading this that they have spent a great deal of time in developing these or in giving them adequate review, even though they may have gone through the holes that are appropriate. I wonder if some of

them weren't just kind of hanging there in the wings and have never even been given a great deal of attention in the past, and now they say:

"Boy, we'd better get these done while we've got the chance."

Many of their projects presumably could be accomplished in short-term, but one at least has a short-term -- two-year time schedule, which obviously precludes its being accomplished in a single year. This is another example, I think, that they have not looked at critically.

They do have a relationship with Comprehensive Health Planning, and are participating in this blanket sort of of agency that is to take over.

They indicate that they have a meeting scheduled in July, at which they will come to some further concrete conclusions about this.

Some of the titles of the projects also raised the question in my mind as to relevance to Regional Medical Programs. Some of them seemed naive -- or I am, and that is possible; some of them seemed clinically oriented, like their clinical research projects, in a sense, rather than educational demonstration projects.

I question, for example, what is their "buddy?" They have something here called a "buddy system," for the role of supporting a buddy in hypertension control. I don't

VHD-106

know if this simply is something like Alcoholics Anonymous -- you call and say: "I'm having an attack; I need your help."

They have a great deal of emphasis on hypertension; they have one which I can't think really can be accomplished in a year's time. I'm not sure really one can evaluate hypertension in a variable population and come to any valid conclusions in a year's time; you can't even collect the data in a year's time.

A comprehensive relaxing therapy. Well, this smacks of accupuncture.

Well, these are the questions I have in my mind.

Number 1, their leadership is unclear.

Number 2, how critical were they in evaluating what is going on?

No. 3, 40 projects seem an impossibility. Some of them are obviously an impossibility by their own statements, and I think that their request for funding is ludicrous in terms of the amount of activity they could really undertake in a year's time and get something out of it.

As Mr. Toomey mentioned, they are asking for $3,700,000, they are targeted for $2,900,000; they are currently $1,400,000, and they want to come in for $800,000 in July.

If you gave them two million now, you would be doing them a favor, and anything they get in July presumably

VHD-107

could be critically appraised.

MR. TOOMEY: The 40 projects they have listed as "Review and Comments" by CHP agencies, the projects entitled "Action taken" -- they are all asterisked as statewide projects that referred to the Councils of the B agencies, but there were four of the 40 projects that were endorsed by these CHP agencies. The other 36 are either "no action taken," "pending" or -- no action or pending. They had four endorsements.

DOCTOR WHITE: I think Mr. Toomey pointed out, and Mrs. Parks certainly did a creditable job in bringing this to our attention, this expansion of funding for some of the operating projects, the doubling of the budgets for some things that seemed hardly valid.

I guess the one exception I might take is, if indeed they have a commitment, which they say they have, from state agency in Michigan, to continue the EMS service at the end of one more year.

MRS. PARKS: Right. This is what I understand.

DOCTOR WHITE: Then perhaps it is a valid investigation.

MR. VAN WINKLE: Doctor White, on the matter of the Coordinator, this was a very strong program under Doctor Hustice, and then there was an interim period before Doctor Tupper came aboard, and the program slipped very badly.

Doctor Tupper turned that program all the way around and brought it right back up to the top.

Tupper left; he's living in Grand Rapids right now, and if you know the geography, that is some distance from where this is located. He is on a full-time job, and I think he is lending his name to this, and I think it is a private commitment on his part to give it some guidance.

MRS. PARKS: He is available?

MR. VAN WINKLE: He is available by phone and by request, but Doctor Graham-Welke was a former staff member whom they brought in who in fact is running the program from day to day, and Doctor Tupper has very little input at the present time, very little input, and I think your criticisms were well justified.

DOCTOR MILLER: Could I ask a question, both with regard to this EMS business, because there is some confusion in my mind certainly, about the limitations on EMS.

Now, here is one; we said -- our directions said that a program in RMD can continue a previously started EMS but can not mount a statewide EMS system.

Well, here is one that has gone from $36,000 a year to $750,000 and it is obviously developing a statewide system, or trying to in one year.

Is this directly opposed to the principle, or is it not? Because we have some others that are coming up where they

obviously got a statewide EMS system.

MR. CHAMBLISS: Will you comment, Mr. Van Winkle?

MR. VAN WINKLE: This is a continuation project.

DOCTOR MILLER: Yeah, but a continuation from $35,000 to $750,000? That is quite a continuation project.

MR. VAN WINKLE: We are aware of this, but they are saying that as far as it being affected by this new law that we can have no new starts, but we can continue to fund what has been funded.

But we strongly questioned this use.

DOCTOR MILLER: We question whether this can be ripened into a full-fledged $700,000 system in one year with a -- with Regional Medical Program funds.

MR. VAN WINKLE: There is one other --

DOCTOR MILLER: I will tell you, practically it is ridiculous. I have had one of those things.

MR. VAN WINKLE: I would like to hear from some of those physicians about this automated peritoneal dialysis also.

The kidney program is going almost totally with home dialysis, using artificial kidney, and now all of a sudden, we are going off, apparently, in this year with automated peritoneal, and I can't very well see people walking around the street carrying a bottle in their hand, and I don't know if it is a part of the Michigan State Renal Plan.

There is no mention of it, and Michigan does have a very highly sophisticated renal program -- you know, a state program that is supposed to cover all of this.

DOCTOR SLATER: Presumably this has all been cleared by their professionals before it ever gets here.

DOCTOR MILLER: Peritoneal dialysis? I didn't think they did it any more.

MR. VAN WINKLE: I didn't think so either.

MR. CHAMBLISS: I think the Committee should know thag both the EMS and the kidney activity will be commented on by the other agencies that are supporting those activities and we will have input from them.

DOCTOR SLATER: Can we put a contingency on this subject to clearance of the technical use of this, despite the fact that they have already approved it at their own -- ?

MR. VAN WINKLE: I think it raises two questions. If this came through their review process, and they are sending it in saying that it has been technically looked at and cleared, then I question the process.

DOCTOR WHITE: That is right. That is why I said on paper it looks good but obviously they have gone through the motions without having any enthusiasm about this.

MRS. WYCKOFF: Don't they still have to get an ad hoc panel of experts on kidney programs?

MR. CHAMBLISS: Are the reviewers prepared to make

HD-111

a recommendation on funding, in the light of the discussion that has taken place?

DOCTOR MC PHEDRAN: I just wanted to ask -- the other people that are likely to comment on EMS going from $34,000 to $750,000; they are not likely to take exception to that. They might have to bear the burden of expense otherwise.

I mean, I don't think that because we think that that is tantamount to a new projet -- we ought to be able to say that that is tantamount to a new project, and we can't imagine anything going from that low a figure to that high a figure without it being a new project, so I think we ought to be able to settle it here and not leave it for somebody else to take care of.

MR. CHAMBLISS: Then we would like your specific recommendations here as it relates to EMS.

MRS. WYCKOFF: Why don't we ask Doctor Dushan to comment on this thing? He is on the panel, and he is a pathologist.

MR. CHAMBLISS: Would the Committee seek that?

DOCTOR MILLER: There is a jurisdictional question, however, that I wish you would answer for us.

We are not empowered to make technical review --

MR. THOMPSON: I don't think we can; I think all we can do is cut the hell out of them.

DOCTOR MILLER: Therefore, if we are facing a technical question, that is beyond our jurisdiction.

MR. THOMPSON: No way.

DOCTOR WHITE: I take exception. We are not looking at the quality -- well, at the peritoneal dialysis, perhaps, but not at the EMS together.

DOCTOR MILLER: No. But about this kidney thing, this is a technical question.

DOCTOR SLATER: Let's ask another point.

Are they requesting funds for services, or simply planning, evaluation? We can't provide money for dialysis, can we?

MRS. PARKS: For the EMS?

MR. CHAMBLISS: For the kidney.

MR. VAN WINKLE: They are trying to determine the feasibility of it.

MR. THOMPSON: You ought to get some kidney people to look at that.

MR. VAN WINKLE: I related it back to process here.

MR. CHAMBLISS: We would simply like to have on record an expression of your reservations, if there are any, and then Staff will proceed further on that.

MRS. WYCKOFF: Couldn't we have the old process we used to have, of a special Committee on Kidney, to look at this for us and give us a report later, or give the report

later?

MR. CHAMBLISS: Yes, we will. That expertise now resides with Doctor Goodman, and we will call upon him to give us input as -- and an assessment of this particular activity.

DOCTOR SLATER: Well, let's leave it that unless we approve it, we don't think it should be included in the figure.

MR. CHAMBLISS: That is very clear.

MR. THOMPSON: The issue, I think, is whether we think it is a whole new project.

DOCTOR MILLER: Mister Chairman, could we get some understanding here with regard to future actions we are going to have to take tomorrow, that a continuation of an EMS project for RMP would be one that is proceeding at not a total statewide plan, unless it previously was approved, and would be of a magnitude of funding similar to what it has done previously, and that anything beyond that, moving in or beyond the jurisdiction of RMP's in EMS, would that be fair?

MR. CHAMBLISS: Not entirely; we have discussed this with EMS and they feel that unless there is a total system involved with all the components of the Emergency Medical Systems, that these activities would be proper for funding under RMP.

But we raised another question of magnitude in terms of funding, and I think that in and of itself would require interaction between these two programs, and a closer examination of the project, so as to take care of the concerns that you express.

We will do that; we will call in Mr. Stryker, and I believe -- Mr. Reardon, and Stryker, and get their assessment of this project.

The level of funding requested here is very high; they have gone, as you have indicated, from $30,000 to $700,000, and we in fact will bring them in and get their views here, and it will be taken into account as this recommendation goes forward.

MR. VAN WINKLE: All we have to look at is a Form 15 here; we don't have, you know, the original application, but it certainly looks like a full statewide comprehensive EMS system.

MR. TOOMEY: Mister Chairman, my recommendation that I have here, on the presumption of the three-quarters of a million for EMS, and the amount of money that was involved in the hypertension, I was going to recommend two and a half million dollars until I heard this morning that hypertension projects are within the province -- and I hadn't counted them but I think there were 13 or 14 hypertension projects.

With this in mind, I would recommend funding at the

level of three million dollars.

MR. CHAMBLISS: You have heard the recommendation. Is there a motion to that effect?

MR. TOOMEY: I so move.

DOCTOR SLATER: Seconded.

MR. CHAMBLISS: It has been moved and seconded that the level of funding for Michigan be set at three million dollars.

Is there discussion?

DOCTOR VAUN: Yes. I find that at serious conflict with the two million dollars that was recommended by your reviewer.

DOCTOR MILLER: I found a serious objection in this.

DOCTOR VAUN: He recommended two; you recommended three.

DOCTOR WHITE: I said we'd be generous if we gave them two million dollars.

MR. CHAMBLISS: All right; we have something of a dilemma here.

DOCTOR WHITE: That's all right; the motion is on the floor.

MR. VAN WINKLE: Was there a second?

MR. CHAMBLISS: Yes, there was a second. All those in favor?

DOCTOR SLATER: Aye.

WHD-115

level of three million dollars.

MR. CHAMBLISS: You have heard the recommendation. Is there a motion to that effect?

MR. TOOMEY: I so move.

DOCTOR SLATER: Seconded.

MR. CHAMBLISS: It has been moved and seconded that the level of funding for Michigan be set at three million dollars.

Is there discussion?

DOCTOR VAUN: Yes. I find that at serious conflict with the two million dollars that was recommended by your reviewer.

DOCTOR MILLER: I found a serious objection in this.

DOCTOR VAUN: He recommended two; you recommended three.

DOCTOR WHITE: I said we'd be generous if we gave them two million dollars.

MR. CHAMBLISS: All right; we have something of a dilemma here.

DOCTOR WHITE: That's all right; the motion is on the floor.

MR. VAN WINKLE: Was there a second?

MR. CHAMBLISS: Yes, there was a second. All those in favor?

DOCTOR SLATER: Aye.

VHD-116

MR. CHAMBLISS: Opposed?

(Chorus of "No")

MR. CHAMBLISS: The motion did not carry in the matter of three million dollars.

That motion is lost.

DOCTOR SLATER: That is the only motion that's been lost all day.

DOCTOR MILLER: It shows we are disturbed.

MR. CHAMBLISS: The Chair is open, then, for another motion.

MR. TOOMEY: I will go back to my original recommendation for $2,500,000.

MR. CHAMBLISS: There is a motion on the floor for a level of funding for $2,500,000. Is there a second?

MR. THOMPSON: Second.

MR. CHAMBLISS: It has been moved and seconded. Are you ready for the question?

DOCTOR WHITE: I would like some discussion.

I would point out again the various number of projects; whether they are meritorious or not is immaterial, one would think. I do not believe that they could have been given the critical appraisal they deserved within the timespan that is allowable, particularly if the leadership has faltered in the meantime; without infringing upon a territory which we are not allowed to get into, I would point out that

ID-117

point out that the specific objectives of the EMS program -- the specific outlets they are seeking, setting of of standards for courses, the training of 1800 EMTA's -- I confess to be unfamiliar with what is involved with that, but it seems to me it is a big number within a single year. Perhaps not.

Perhaps the evaluation of this program as to its benefit to Michigan, I don't think you can evaluate it in a year's time; you can't even get it done, so I don't think you can evaluate it, in a coordinated statewide EMS component to be assumed by the Michigan Department of Public Health.

Now, I will retract a statement I made earlier, that if the State Department is going to take over, perhaps this is worthwhile, because as I read this now, it appears to me that perhaps the Michigan Department of Public Health is going to take over responsibility for training rather than for the establishment of existing programs.

Therefore, I doubt that $750,000 is a wise investment.

DOCTOR WHITE: I don't think we should settle this question without begging the question, I guess.

MR. TOOMEY: The funds requested are for program staff of approximately $350 thousand and for the continuation projects of approximately $1,675,000, which gives you, at two million dollars just to continue their project staff, their core staff and their program staff in the continuation

HD-118

projects. That two million dollars allows for no additional projects.

I mention that merely as a sidelight. If the concern is a further reduction from the two and a half to approximately two, as I said, this allows for continuation.

Now, I will once again admit that their $600-700,000 -- and I did the arithmetic very quickly -- in hypertension projects -- in some of them, for instance, hypertension projects in the Detroit Department of Public Works, as an example, and then you mentioned, Doctor White, the buddy system of hypertension, whatever that is.

And then on top of that, you know, I am extremely skeptical of the -- in the application anyway, but I hate to cut them down to exactly where they are -- where we are now.

DOCTOR MILLER: Question, please.

MR. CHAMBLISS: Is there further discussion of the motion on the floor? It has been moved and seconded. Shall I call the question?

All those in favor of setting a level at $2,500,000 for Michigan, say "Aye."

(Chorus of "Aye")

Those opposed?

(Chorus of "No")

MR. VAN WINKLE: Almost all ought to have a show of hands.

WHD-119

MR. CHAMBLISS: I would ask for a show of hands, please. Those voting "Aye," may we see your hands?

(Show of hands)

MR. CHAMBLISS: Five in favor?

Those opposed?

(Show of hands)

MR. CHAMBLISS: The "Ayes" have it and the motion is carried.

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REGIONAL MEDIAL PROGRAM REVIEW

MISSISSIPPI REGION

MR. CHAMBLISS: May we turn our attention then to Mississippi? The reviewers there are Doctor Vaun and Mr. Toomey, supported by Mr. Van Winkle, and I should make mention of the fact that the Committee has set as its goal the review of three additional Regions this afternoon, and there will be two left when MIssissippi is completed.

DOCTOR SLATER: What are the others, sir?

MR. CHAMBLISS: Illinois and Louisiana.

DOCTOR VAUN: First, I should be -- should issue a disclaimer. My daughter happened to be looking through this; she looked at the pictures and I didn't, and she said: "Daddy, you needed a haircut for the picture."

Remembering the nature of the visit, however, I am sure there was no effort on Doctor Lampert's part to seduce me into giving him more money, and I will describe the nature of the visit, which has, I think, some bearing on the issue.

MR. CHAMBLISS: We will not consider that as a conflict.

DOCTOR VAUN: I think it was September 1972 when Doctor Joe Hess and his storm-troopers went down to straighten up the Mississippi Regional Medical Program. They were having a great deal of difficulty and they went down there to take them to task.

ID-121

I must admit retrospectively, as I look back on what we did when we were there, we might have been a little too critical for Mississippi not having evaluation of their projcts, because in the subsequent years I haven't seen much evaluation of anything from anybody, let alone Mississippi.

But nonetheless, they were in trouble with leadership problems, and the question that kept coming across the table during the day was: it is very hard to tell where Ol' Miss ends and RMP begins, and that was a serious problem and there seemed to be a great deal of incest between the program and the Ol' Miss. I am indeed pleasantly surprised to see this summary of projects come out these years later, because whether it was us or whether something has happened down there, certainly this is a pretty good piece of work that has come out since then, and I am rather pleased with it.

I think it would suggest that there are some strengths there that we did not identify at that time, but Doctor Lampert has obviously done a pretty good job of his burden of sustaining staff through a pretty rough time.

It would appear that the CHP relationships are satisfactory. I think that here the projects address themselves more now to the health care needs of Mississippi rather than to continuing this so-called soft money for the University of Mississippi when NIH was phasing out and other aspects of that nature.

VHD-122

Maybe it said the General was no longer there, but there was a retired General down there who was running at that time the University of Mississippi and also seemed to be, to a large part, with a certain lady, running the RMP.

Things have changed, and I think that though their request at this time is unrealistic, I think that the RMP of Mississippi deserves a few pats on the back.

I am recommending a reduction of funding which I will hold until Mr. Toomey has his licks, and then together we will recommend something to you.

MR. TOOMEY: Well, once again I am following the format; I felt the program leadership was strong and viable. I felt the program staff to be competent.

RAG meets, the Executive Committee meets, the Planning Committee meets, the Manpower and Education Committee met several times, Health Systems and Public Education.

Their past performance has been impressive; for instance, I don't want to go into these, but the first stroke and intensive care unit, care and training, the first chronic pulmonary disease unit, treatment and training program, the first on-going effort toward coordinating continuing health education, the first system for coronary care and training -- and there really are a dozen of these "firsts," that indicate the impact of the Mississippi Region on -- the Regional Medical Program on the state of Mississippi, and frankly I felt it was

quite impressive.

Additionally, they were extremely -- I felt -- perceptive in establishing goals and they were quite precise in the establishment of objectives in order to support the accomplishment of those goals.

The proposals that they have are congruent and they certainly mesh well, generally speaking, with the proposals that were made.

I looked at the CHP comment, the state comprehensive plan came with an endorsement of 39 out of 59 projects that had been proposed. There were four responses from comprehensive health planning agencies, and the tone of these responses were all extremely cooperative, extremely friendly, and seemingly with a good relationship between the two.

One of the items -- perhaps Doctor Vaun mentioned this -- but we again run into the situation where the funds for the continuation of the projects already proposed or already on the boards is $1,200,000 and their proposals -- the funds for their new proposals are $1,155,000, which means that requests for new funds are just about as great for -- as for the continuation enterprises.

In brief, I think that this was an extremely well-done proposal; it indicated a considerably higher degree of strength than several of those that I have reviewed earlier, and I ended up with an evaluation of this project as being in

a good to excellent stage.

DOCTOR WHITE: Mrs. Wyckoff has been doing a technical review here and has a question to ask.

MRS. WYCKOFF: What is "Pierre the Pelican"?

MR. CHAMBLISS: That was a policy question we raised too; we wanted to know.

DOCTOR VAUN: I thought I went through that very carefully, and I don't remember any pelican.

MRS. WYCKOFF: Pierre the Pelican is No. C-179.

There is also 137, "Solid Waste," and "Solid Waste Management Training."

MR. VAN WINKLE: It is education of illiterate mothers. It is a pamphlet that goes out; it is quite well done.

MR. CHAMBLISS: Would the reviewers have any recommendations here?

DOCTOR VAUN: Our independently arrived-at judgments are reasonably close it would appear, so I would make a recommendation that the Mississippi RMP be funded for $2,200,000.

MR. CHAMBLISS: Is that a motion?

DOCTOR VAUN: I so move.

MR. CHAMBLISS: Second?

DOCTOR WHITE: Seconded.

MR. CHAMBLISS: It is moved and seconded that Mississippi be funded at a level of $2,200,000.

WHD-125

Are there questions or discussion?

DOCTOR MILLER: Yes, I would like to ask the reviewers: did you look at the magnitude of the collective -- of the renal programs?

I see two programs which total $230,000; are they running a statewide renal program, and is that contrary to RMP principles?

MR. CHAMBLISS: No, it is not contrary.

DOCTOR VAUN: But that, plus a few others, when I said I arriv ed at my personal evaluation --

MR. VAN WINKLE: I raised the question because of the substantial increase in the costs.

They are opening up a new unit and I think we will have to flag this for Doctor Goodman, in kidney, because it is an expansion for dialysis facilities. We want to be very sure whether they have proper clearances on this sort of thing.

DOCTOR MILLER: How about EMS here? It goes from 17 to 92; that is only four and a half times, it isn't 20 times.

MR. CHAMBLISS: We don't see the magnitude there that you referred to earlier on, Doctor Miller.

DOCTOR MILLER: No, not quite.

MR. THOMPSON: What happened to the turf problems they were having with Memphis for a while?

MR. CHAMBLISS: There has been an agreement between the two Regions on the overlap areas in Northern Mississippi, I believe, has there not?

MR. VAN WINKLE: Yes, including the CHP A agencies. As a matter of fact there is combined funding.

MRS. WYCKOFF: There is a beautiful interface and it is working very well; very nice interface -- joint funding, joint meetings, both RMP and CHP.

There is one CHP in Northern Mississippi and both Mississippi RMP and Memphis RMP have funded it and started it --

MR. VAN WINKLE: And are evaluating it.

MISS MURPHY: Right, and it is a very nice interface.

MR. CHAMBLISS: Shall I call the question then? All those in favor of the motion?

(Chorus of "Aye")

Those opposed?

(No response)

The motion is carried and the level is set at $2,200,000 for Mississippi.

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REGIONAL MEDICAL PROGRAM REVIEW

ILLINOIS REGION

MR. CHAMBLISS: Shall we now turn our attention to a review of the Illinois Regional Medical Program?

Doctor Slater is here, Doctor Scherlis is not here, and --

We have Staff support for you, Doctor Slater, in the person of Mrs. Kyttle, who is very knowledgeable about that region.

DOCTOR SLATER: I was just going to say, Mrs. Kyttle and I have power of veto over this group, because we both agree that Illinois is first-class, recommend it have full funding; I have nothing adverse to say and I am handing in my recommendation as good-excellent, with a final superior at the end.

Do you want to hear about this program? I would like to tell you, because I think it is really good.

You may take my light-hearted vein as a little bit of hypoglycemia.

All right. I think the main reason to proceed with this is really to bring into focus the orientation that this particular program has, which I find exciting after having listened to points of view expressed from the various regions today.

The staff role -- the program leadership, as I can

make it out, has been very strong. Doctor Creditor has been able to carry a very strong program forward while phasing down. He went from a professional staff level of four -- this has now been built up to approximately 12, and he counts on a few more people but he does not plan on grossly expanding the central staff, despite a considerable -- a 100 percent expansion of funding requests.

During the course of the phasing down they felt that there was a great deal to be learned out of the experience they had been through, and joining forces with the CHP, they actually sat down and looked at the planning techniques and the outcomes and developed a planning model which was built on the comprehensive social approach to health care planning. It was for this reason that they really wanted to spend a couple of million.

They finally published a book which has just come out, on health care development which I think is worthwhile spending a moment on, but as back-up on this I can say that the RAG had been intimately involved in this along with CHP, and in general, the program, against this kind of backing, has been organized into two types of approach.

A health process approach, if you like, which is looking at problem-oriented medical records, patient education techniques, on the one hand, and disease-oriented programs, improvement and specific care, models such as kidney,

HD-129

cancer and hypertension, on the other.

They have elected, within that framework, to put a great deal of emphasis on a few specific types of prominent concerns. Problem-oriented records, for one, and problems of hypertension for another, and thus have in-depth experience with a high investment history in those two areas, and at the same time they have had very good out-reach to the disadvantaged urban areas as well as the areas in the Region of Chicago, in terms of the types of RMP support for primary care and the like, which I will mention briefly.

Let me just give you an inkling in their approach to planning. They decided that rather than take the rather global, generally-stated type of expression of goodwill that has been really traditional to RMP's, they would take an objective approach to planning, so they sat down with the CHP group and the RMP group and said:

> "Well, what are the human goals? What are we attempting to achieve here? And within that framework, what are our objectives?"

Objectives being slightly more sharply defined, and then, out of this one comes health-care goals -- more specifically, health-care objectives, and then down -- finally down to programmatic goals.

So that, one: when this was developed with the people they had available, they were listening to consumers

130

as representatives of CHP, and finally coming out with RMP professional providers providing an answer to the expressed desires of the people in that Region.

A couple of examples. At the Human Goals approach, the most broadly oriented description, the people wanted optimum functioning of the health system, optimum longevity of life, optimal tranquility.

Well, this is pretty general when you start moving along to the kinds of interpretations of objectives. The lay people said they really wanted to be able to prevent disease, they wanted to be able to cure curable conditions and treat treatable conditions.

It is interesting that Creditor goes on and says:

"The interpretation of those sets of objectives by any group in an area really is dependent upon the make-up of the group, and depending on the environmental-educational-health orientation, socio-economic relationships, you may come out with a variety of different projects which lead to these ultimate goals."

So that on the basis of that CHP type ofactivity, the provider looks at this, then comes down to the presentation of health-care goals, which is emphasis on accessibility, quality of care, effective management, optimum cost relationships, and so on.

Moving to another stage down the line, they take a

HD131

more sharply defined look at objectives, such as improving the understanding of health care; specifically, availability of the entry points of the system, optimal relationships of the system.

I won't go on, except to say that when they get to programmatic levels, they have specific series of approaches that can be taken within these health care objectives, and then they have taken a variety of programs or projects which have been fed into them from the Illinois area, and categorize them specifically as meeting these objectives within the framework as a whole.

Now, that to my mind, is a pretty neat way of putting in specific terms of reference some workable pattern, instead of five lines of such general statements that one wonders what -- whether or not the thinker is very clear when he is attempting to do it.

It does provide a procedure to examine what projects one is covering now, where there are gaps in the system, and it really puts into a highly analytical form some of the more philosophical objectives that we are groping to satisfy all the time.

So I was impressed with that, and that is the project of the phasing back. They have taken time to analyze where they have been and where they are going.

So now, everything that is presented in the present

WHD132

proposal is cast within those general frameworks, and all batted out by the RAG and Comprehensive Health Planning.

Well, I guess, against that background, then, how have they performed?

They have had a series of projects, I think, that there are about ten here, which have been started up over the past few years and in one way or another have been spun off and picked up fully operational by other groups.

Health care at home has been picked up as a free-standing enterprise by a group in the area.

Health information and referral is terminating because they had inflated ideas about what they could perform and they just decided to phase it out.

Multiphasic screening in industry has been picked up by the Heart Association and shared with a variety of industrial managements.

I won't go into all of them, except to say that they have had a series of specific projects started, proven and moved on out while they used their funds catalytically to start something else.

I was interested then in a series of proposals that they put forward. I have not mentioned that part of the specific activity -- well, which I just mentioned in passing -- part of the specific activity is to go into depth on how the problem-oriented medical record might be more

WHD133

effectively utilized, and then put a great deal of funding into that in the past, a great deal having been spent in teaching other groups and institutions how best to use the problem-oriented record, and they have about four pages of institutions and groups, that they have set up training and demonstration programs for, and they plan to continue that in this next year.

The other major venture, of course, has been in hypertension, and they have been attempting to develop a computer technique which will provide a simplified diagnostic and therapeutic protocol for that. In fact, relatively simple screening and input of information can provide back a protocol which is applicable to large numbers of people in the disadvantaged areas.

I am fascinated by the fact that they figure they can have that computer program so that it is about ten cents per computer run after you go through the matter of data collection, and input.

So the proposals then boil down into two parts: those that are going to be continued, and those that are going to be new.

Problem-oriented record -- they want to proceed with implementation, as they have already been doing, for $105,000. They sent in an evaluation report, and the evaluation indicated that this was a very influential program up to

WHD134

now.

The computerized hypertension treatment, they needed to continue to work on that, and that is $205,000. A group of physicians in residence out of Champagne County are looking to problem-oriented record systems integrated into what is called the "Plato 4 Dance Computer," about which I know nothing. Apparently it has been funded before and they want to continue that into the future.

They have had a Chicago alliance for VD awareness under way, and that is to be continued.

Peoria frozen blood program, which is simply a matter of providing frozen blood for people in need, undergoing kidney dialysis and other types of extreme problems.

Now, the new programs have moved beyond the existing problem-oriented record to take this out into ambulatory care programs that they have in the out-patient program department and elsewhere, for the next year, and they provided evaluation as well as to the effectiveness applied to ambulatory care. $128,000.

And then a nice little touch here. The Christian Action Ministry are concerned about access to care services of a broad type; inner-city health and social needs. This is such matters as day-care centers that have a health component, and they all interact. Not much -- $44,000, but well-spent money, in that type of thing.

WHD135

They want to hold a series of dialysis consumer workshops for $30,000. Again, I think a valuable type of patient education.

And Access Chicago, a rehabilitation institute program, to take a look across the city and find out how barriers to handicapped people can be decreased and develop this as a public monitoring system; just $12,000.

And then, finally, this is interesting because I would like to know about this project; an institutional cardiovascular center. They are asking for $100,000 to help organize this. This is against a background grant of $38 million to pull together eleven institutions to develop a multi -- or at least a consortium of activity in cardiovascular disease.

I think that is real original planning. Who has that proposal? Does anybody have that?

MRS. KYTTLE: National Heart and Lung.

DOCTOR SLATER: I would like to look at it sometime; I think this is what cities need to do more of.

Finally, they are asking for $643,000 for statewide hypertension control program. That is going to be built on their model, which is going ahead from the present fnnding because of the action -- the present action that they are also funding for -- 350,000 inner-city people who are going

to be programmed into that computer and hopefully monitored.

They have developed a very fine record of starting little projects and seeing that they work,either spinning them off or expanding them up to a broader application at the state level, and clearly they are moving in the direction of hypertension.

Now, looking at all of this in terms of the feasibility, I would say that the feasibility of what they are asking for this year in new projects have a good chance of flying, and if they run out of funds by the end of the year they will spin these off or re-fund them or find ways to carry them out. That has been their record and it has been very successful.

No question about their relationship with CHP , and overall, I give this a rating of superior, and I feel that I would recommend that they have all of the funds they are asking for, which is only 78 percent of the funding that is allocable to them, and if there have to be any cuts at all made, we provide them the chance to cut back where they deem fit.

I doubt if that is going to be necessary.

MR. THOMPSON: I guess I have one problem. I wish somebody would do what the RMP did in the early days when finally we got sick and tired of giving money to computers and money to this and that, and finally somebody came in with

a big print-out out of a computer, and told us all the money was being put into computers.

And I want to know how much money is being put into the problem-oriented record. Not only here, which is a $3 million grant going up there out of Research and Development, out of Gerry Rosenthal's shop. I mean, boy! I don't know where all that money is going.

I am not against the problem-oriented record; don't get me wrong. This is kind of getting over-killed with money.

DOCTOR SLATER: Do you think it would be worthwhile for RMP as one of its final acts to lay on a sophisticated -- a professional visit, not just to this program, but to take a look at the financing of problem-oriented records or computer-type programs just so as we go out of business here and face probably a lot more money available through other agencies in the field, where we are at with this?

MR. THOMPSON: Now we are talking about something else. What does it -- what is the take out of all the RMP activities?

DOCTOR SLATER: Well, you would like to get a national fix on this; it would be interesting to have a playback from the other Regions.

MR. THOMPSON: Computerizing the problem-oriented record? That is a new catchword, along with " quality assurance."

MR. CHAMBLISS: I do think that is a rather substantive question you raised.

The Council did look at multiphasic screening in the same way that you are looking at the computerization of records. I don't know how we can go about getting a fix on that; we will raise your concerns, though, and appreciate your observations here.

MR. THOMPSON: Well, you know, we went through that cervical screening mess for a while. You know, that was all there, and if you read --

DOCTOR SLATER: That's a horse of a different color. I think that here you are really providing a real aid to differential diagnosis and the position tracking of the patient; the cervical diagnosis was prefaced on incorrect information.

MR. THOMPSON: I am not arguing about the validity of it; I just wonder how much bucks?

DOCTOR SLATER: I would like to pick up Mr. Thompson's concern and say that I feel this program is working, is producing so well that we should not hold back on the funding for this, but that the larger concern that is raised by this type ofactivity probably will be the basis for a recommendation for a task review of not what just RMP has been doing, but an overall picture of the Federal Government in supporting this type of activity, and what is its meaning,

what is the situation today?

MR. CHAMBLISS: Doctor Carpenter?

DOCTOR CARPENTER: I have some questions about the problem-oriented record, too. You need a piece of paper at a staff meeting and you have to have something on the paper in order to make it go, and I don't understand what the money is for.

MR. THOMPSON: They are all computerized.

DOCTOR CARPENTER: What I actually want to raise is the issue of $643,000 for screening program for hypertension.

MRS. WYCKOFF: It's a million if you count the other two projects with it.

DOCTOR CARPENTER: Okay, a million. Thank you. How many previously unrecognized hypertensives will be brought to treatment as a result of this program, and who will do the treating?

DOCTOR SLATER: Now you are getting into project detail for which there is not information here.

DOCTOR CARPENTER: I am raising a management question; I think if those questions have not been dealt with in the application, there is something wrong with the Region's management.

DOCTOR SLATER: I am assuning that the quality of the review process, if it is affected by the quality of the

WHD140

way this is written, can answer that question. I can't answer it.

MR. CHAMBLISS: Do you have comments, Mrs. Kyttle?

MRS. KYTTLE: I don't know the preciseness of the treatment, but I know the protocol and the thrust of the proposal, and it is an impirical thing.

It mobilizes the state into local organizations that will specifically survey for hypertensives, assure that they are recognized, identify, treat it in a fashion so that the rest of the state can get the information, so that the basic data shows in Illinois that hypertension is epidemic.

But no one is organized to attack the problem, and this is not so much a treatment of the specific patient as it is organizing the system of care that treats the patient.

DOCTOR CARPENTER: What part of that budget is invested in personnel?

MRS. KYTTLE: I can tell you that in just a minute. $48,800 -- no, no; wait a minute. I have the wrong one.

$291,000.

MR. THOMPSON: How much?

MRS. KYTTLE: Out of $743,000 -- no; excuse me.

$100,000 of it is coming from other sources, and the $743,000 is the total cost, but RMP is being asked for $634,000. $291,000 is a line item for salaries and wages; $170,000 for equipment, $28,000 for supplies, $15,000 for

WHD141

travel, $23,000 for rent.

It creates local consortia of some type, and there are charges listed here, and $25,000 in the other categories.

MRS. WYCKOFF: How is it related to Project 18 and 32?

MRS. KYTTLE: This is statewide; 18 is Mid-State and Southside. Southside is a cooperative B that Illinois has used as a springboard for a lot of its activity that it tries out in Mid and Southside, and then comes off a later timeframe as a national --

DOCTOR SLATER: This is not a final program, but they are estimating a million hypertensives out there; 360 in this experimental program.

MR. THOMPSON: My concern now -- well, two questions.

One is that you said the control program is based on a computer print-out, computer diagnosis.

MRS. KYTTLE: That is in a controlled population.

MR. THOMPSON: Yes, I understand that, but somebody said that they were fooling around with some kind of a computer program in hypertension, and would apply this computer program -- which again, unless I misunderstood you, is not completed yet -- to a statewide control program.

DOCTOR SLATER: I think I left that impression.

MRS. KYTTLE: The precepts of that program will be

WHD142

fed to the local boards that will be established, but to speak to the whole future of the thing, three things have happened in Illinois all at once, that the Illinois Regional Medical Program has been waiting for for a long time.

They got a new A man; they could not move statewide well with their former CHP A man, who was replaced by a former Board member of the Illinois Regional Medical Program Board of Trustees.

The concept of the key factor analysis for planning has been a philosophy of the program before phase-out but could not be moved statewide because it met A opposition.

It no longer meets A opposition, and they are now able to move it.

They have a new State Health Officer who is a former RAG member, and she is now working with the program in statewide areas that they have not had an opportunity to work well in before, and most importantly of all for this project, we are thinking about now the statewide hypertension, and we have a new Governor that stood off from that -- from matters medical.

No one, not the A man, not the new Public Health Director, and not the existing RMP could open his door, because he had other assessments to make. He only now has established someone in his office to work with the Illinois Regional Medical Program to develop a regional legislative

HD143

package.

They got to him with the epidemic hypertension figures, and he is working with them for a legislative package that they hope will continue much of this.

DOCTOR SLATER: Let me give you the wording on this, John. I think we may have it here:

"The immediate objective is to develop a state network of hypertension registries which is to evaluate quantity and quality. CHP B agencies would be asked to assist in components of the program, which in turn will mobilize regional resources to determine registry input, reporting of requirements and action to be taken in terms of screening, referral, management, and consumer and professional education.

Discussion has begun with state officials, and heart association legislation."

MR. THOMPSON: Is it against the law for CHP B agencies to run programs? They are not the implementers, if that is the question that I hear you stating.

DOCTOR SLATER: CHP B agencies will be asked to assist in regional components of the program, which in turn will mobilize resources and essentially determine registry input, and so forth.

MR. CHAMBLISS: There is a substantive issue here, I think, and that is one of balance on the part of the RMP,

and is there -- and we would like your judgment here -- is there an over-emphasis in the area of hypertension, especially since there are 350,000 people to be screened on the computer set up?

I simply throw that out for your assessment. Of course we would like to have your views here on feasibility.

DOCTOR SLATER: My impression of this as I read it through, and I would like to hear what Mrs. Kyttle's understanding is, having visited there, is that they made a specific decision programatically, sometime ago to go to two routes.

One is to satisfy some of the start-up needs of what you might call community-action programs, health care access and the like, which have been reflected in these programs that have been passed on, and are not free-standing.

And the second decision, some of these mass-population approaches which are clearly associated with the mechanical improvement of screening and information gathering, so they can be applied to masses of individuals who are disadvantaged, and in order to get to that level of technology, they need a reasonable level of hardware, as John was putting forth.

Now, I think the question is whether or not this is incorrect, that at the national level we have decided likewise to go this route of kind of the task approach to cancer --

originally it was heart disease, cancer, stroke, and now even more so we have oriented our efforts on a programmatic basis to such things as cancer.

So I have trouble making a decision at this level based on the -- that they have done the wrong thing. I think they have taken an experimental approach as part of the pluralistic way of going about it, and they are not doing it to the exclusion of all other activities.

They could have a lot more Christian Action Ministry, and I think they might -- I think that would be very effective and I am sympathetic to that, but I say there, they decided to put a lot of money into this one orientation.

DOCTOR VAUN: I move that Illinois get their full request.

MR. CHAMBLISS: All right. There is a motion on the floor, and will you cite the dollar level that you are referring to, please?

DOCTOR SLATER: I suggested that they get what they requested -- 78 percent of what you indicated.

MR. VAN WINKLE: $2,816,935.

DOCTOR WHITE: I'll second.

MR. CHAMBLISS: It has been moved and seconded that Illinois be recommended for the level they have requested, $2,816,935. Is there further discussion here?

DOCTOR MC PHEDRAN: I guess I'll go along with that,

but I think we ought to mention we think it is going to be difficult for them to spend that amount of money on hypertension, on the hypertension identification in that length of time. I really think it is going to be hard.

There are places where similar efforts have been tried in the past. Doctor Joe Wilburfore, in Atlanta, and there are a lot of problems with it, and the implications that Doctor Carpenter makes are a very important one.

That is, in places where there are a large number of hypertensives, particularly in deprived people, it is extremely difficult to get them into effective treatment programs, and it always seems a pity to identify a lot of them and not be able to follow up at all, and I think it takes away from the luster of the Regional Medical Program that is engaged in an activity like that that is effectively followed up.

So I think -- I guess that maybe is one of the things that Doctor Carpenter is concerned about.

DOCTOR SLATER: We are more concerned about the fact that they are attempting to do too much in too short a period of time rather than that.

MR. THOMPSON: Plus the fact we have gone through cancer detection, we have gone through multiphasic screening, we have gone through all these kinds of things where everybody runs around, finds a lot of pathology that nobody sees until

WHD147

the damned stuff is treated, because it is outside the system.

MRS. KYTTLE: Mr. Thompson, not in Illinois. When I followed up there, Illinois had an interesting spin-off from the follow-up.

It was referring all of these people with identified hypertension to doctors, and the doctors all said:

"You know, I've got sicker people in my office."

And so the RAG in Illinois decided that one of the spin-offs from their next controlled hypertension would be to educate physicians to treat mild hypertensives. They were willing to take on the referred critical hypertensives, but they couldn't get the mild, even though they followed them up, they hauled them right into the doctor's office and that is where it fell down.

MRS. KYTTLE: But you know, some screening dropped the man and didn't follow up, but they did not. They followed up; they re-screened.

DOCTOR SLATER: It is very important; even if it is negative, it is certainly something that helps the system.

DOCTOR MILLER: Mister Chairman, could I ask a question?

I have known a good deal about the Illinois program, and to a great extent the strength of the Illinois program is directly related to Doctor and Mrs. Creditor.

Doctor and Mrs. Creditor are both moving to Urbana,

WHD148

and though he is going to spend 25 percent of his time on continuing this program, the magnitude of the effort has got to be led by somebody better than just a Creditor on 25 percent of his time from Urbana.

What assurance do we have that a similar competent person is going to take over or that he will be able to help recruit, or maybe can we help them recruit one?

DOCTOR SLATER: I apologize for forgetting to mention that.

MR. CHAMBLISS: That is very critical, yes.

DOCTOR MILLER: The two of them ran that program.

MR. CHAMBLISS: Would Staff have any comments on the efforts in recruitment there?

MRS. KYTTLE: What I mean -- well, as I mentioned in my staff paper, the Board talked with Dean Bloomfield, and I have talked with Dean Bloomfield.

The Board has decided that 25 percent of Doctor Creditor, which they think will also bring them 25 percent of Mrs. Creditor for free, is good enough, and they would rather go with that than to recruit hastily. They are recruiting; they have a Search Committee.

Bloomfield is a member of the RAG; he is deeply involved in the problem-oriented record. That is how a lot of it got going down in Smithfield or Champagne and Urbana in the first place. Dean Bloomfield assures the Board, and me,

VHD149

that that is not going to be a skimpy 25 percent, and that it would be his assessment that it would be the better of the two arrangements, at least through December, and recruitment efforts are going on.

They have found no one; the Board wants an M.D. and tney are simply not coming up with a successor to Doctor Creditor, and there is no assurance.

MR. CHAMBLISS: I would simply ask the Committee, is there a judgment that it wishes to express on the issue of recruitment?

DOCTOR WHITE: I would like to agree that the Board is using some sense, because I can't imagine,knowing what is going to happen in July of 1975, that they could get anybody who is really effective as a replacement.

DOCTOR CARPENTER: There can't be anyone who could solve the problem of bringing 66 percent of the hypertensives in a population to effective treatment that wouldn't make a national contribution that would be enormous. That will take someone five years of his life to prove that he's a relative failure in this area, as a lot of people have done that in other screening areas.

Is there a Project Director here that we have not heard about who is committed in the long run to the control of hypertension in a population?

DOCTOR SLATER: Doctor Kyttle -- Doctor Koe. Can

you talk to that?

MRS. KYTTLE: Well, they thought Fred Coe might have met this, but he can't at this time. Can not be distracted from what he is doing.

Doctor Creditor is temporarily listed as the Project Director in hypertension. That is temporary, and it is almost a cloak; because this project creates a State Board, they have proposed a candidate, and I do not know who it is, that the Public Health people, the CHP people, the Medical Committee and the IRMP would proposed to the Governor's office, and now that the Governor's office has gotten involved, and this they look at as the possibility of the project for the hypertension effort being the continuing Regional Medical Program Director.

So they are approaching it cautiously, because the man has to be ratified by so many different interests.

MR. CHAMBLISS: We have a call for the question?

The motion has been to recommend a level of funding for Illihois at $2,816,935.

All those in favor?

(Chorus of "Aye")

Those opposed?

(No response)

One in opposition, and the "Aye's" have it.

I would say that with regard to Illinois, the

0151

discussion will be noted and taken into account, as presented here by the members of the Committee.

I would call your attention to one thing, that our workload for today is still one short, interms of the number of Regions to be reviewed.

The last Region for today is Louisiana; I would have a hope that we might finish by ten after 6:00. Is it your pleasure to continue? Let's go.

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REGIONAL MEDICAL PROGRAM REVIEW

LOUISIANA REGION

MR. CHAMBLISS: All right, the reviewers for Louisiana are Doctor White, who will be supported by Mr. Zivlavski.

Doctor White, will you proceed, please?

DOCTOR WHITE: I am sorry that this comes at the end of the day, because I have yet to make up my mind what should be done about Louisiana; as I was saying earlier to Doctor Vaun, I had a feeling I was in an intensive care unit, and I really had a patient who had died but was on a respirator and I didn't quite know how to pull the plug.

Yet, on second thought, perhaps there is a feeble beat going on there that I didn't detect at first glance, and maybe something can be salvaged.

Well, with that as a preamble, you can see my confusion.

Louisiana has had a checkered career in the past. It had a Regional Medical Program, but it has never been awarded a triennial status.

It was a difficult chore to even get the concept accepted in the state of Louisiana for many years. Doctor Zabatlyea took on the job, I forgot when -- sometime ago; he had been President of the State Medical Society, he was an acceptable individual, and on the basis that they knew him and

VHD153

on the basis t hat the thrust would be on planning initially, it got off the ground, and in reality the Regional Medical Program has functioned there for a number of years much like the CHP agencies were supposed to function.

And on a site visit a year or two ago, this was noted, and I was asked then that a Regional Advisory Group begin to become more action-oriented. At the same time we became aware that Doctor Zabatlyea was really running this thing; the Regional Advisory Group was sort of there in name only.

Mr. Smith then took over as Regional Advisory Group Chairman and turned things around, but only at the time Washington was turning around, and this disillusioned them totally. Doctor Zabatlyea resigned from his position, and I guess is now donating some amount of time, and a doctor whose name I don't recall -- a dentist -- is filling in for him.

The other problem in Louisiana is -that there are two systems of medical care, and the two seem not to be meeting. Although, as I have down here, there had been some change under way when the axe fell.

So the leadership is in question at the present time. This report that we have before us was prepared by a task force, signed by Doctor Zabatlyea but obviously not the product of his thinking. It is rather disorganized, it does not follow any sequence that permits you to see the program as

a whole.

The staff has been reduced considerably; there are four and a half professional people listed with presumably, as I mentioned -- the Regional Advisory Group began the turn-around, but I have the feeling that now they really developed phase-out plans and when this new concept came along they kind of even delegated this development they had not expected to others.

I am not sure from the narrative how often the Regional Advisory Group has met, and as I said, I do feel that probably their work has been delegated to staff in some existing communities.

The past performance of this has not been good; they have begun some outreach programs in some of the rural areas, they have begun some patient care program activities; they are proposing others, and -- in this present package.

They have participated in the established Emergency Medical Service programs in the state, the two direct efforts toward hypertension, quality assurance and outreach counseling.

They do recognize, and I guess they have been atturned to this for some time, that they may not get money for more than a year at a time, as they have in the past, so I guess it is nothing new to them.

Their efforts are reasonably feasible on a year's

budget period.

One plus is that the state itself has finally reorganized its health-care delivery systems, evaluation systems, and has a centralized state agency which will take on and direct, presumably, many of the things that are going on in the Comprehensive Health Planning agencies, many of the things that have been going on in the Regional Medical Programs.

This was accomplished in 1972 when this consolidation was under way, and it seems to be accepted; funded by the state, at least partially, and for that reason, if nothing else, I would suggest that this request by Louisiana, even though we know the leadership is not good, at the present time, and that past performance has not been good, that there is some merit now that the state has begun to move in the focused direction, in not cutting the rug out from under them, with the hope that at least some amount of money will continue the emphasis toward this simple direction of the health services.

That is the only justification I can find at all for recommending any sum of money for Louisiana whatsoever. Some of their projects are adequate; a couple of them are rather biased, I think because the Director at the moment is a dentist. They have a couple of fairly sizable dental programs, including a mobile bus that is going to go out and fix teeth, I guess.

We have another strange one, or at least it seems funny to me; they are going to establish a Midway assessment Region at the Charity Hospital, and as I read some of the comments, this is to move the patients out of the wards into another place, because these are patients they can't get rid of -- families don't want them back, they don't have any money to pay nursing care, and that is one way out. And the Midway Assessment Region is for patients flowing the other way, that come in through the Emergency Room and can't be evaluated adequately, and they have to be placed in this area and then moved into the hospital or someplace eventually.

But anyway -- they are at least making some efforts at bringing some services to people who are denied services at the present time.

Another one at the Earl K. Long Hospital -- they indicate that there is a 60-day waiting period for patients to be seen in the clinic, and they are asking a modest sum of money to open up night-time clinics and weekend clinics so that this waiting period might be shortened, and I guess that is reasonable.

DOCTOR SLATER: Well, that is straight operational patient-care delivery.

DOCTOR WHITE: Well, it is going to support some staff work to help administer that.

MR. THOMPSON: You can't do that with a modest sum

ID157

of money.

DOCTOR WHITE: Well, I get through saying these things; it's a bad bag all around, and yet I don't feel that it should be denied survival for as long as the rest of them are going to survive, in the hope that one more year might see something turn around even more.

They have asked for $985,000, which is only 77 percent of the targeted funds, which would go to them on a formula basis.

Mr. Zivlavski, maybe you have some comments before I come up with recommendations?

MR. ZIVLAVSKI: There are several negative comments which you made, and I hope I can cover these comments.

The phase-out of the Louisiana Regional Medical Program was taken very seriously by their Board of Directors; as of July 1st of '73, Doctor Zabatlyea was only part-time, and a -- business management was basically left to the Board staff.

This was a non-profit corporation, by Louisiana law; they have to notify the state 60 -- six months in advance before terminating the corporation.

At that time Doctor Zabatlyea did reduce his staff; he was on approximately 20-25 percent. He remained as a part-time coordinator.

In late June things did change. In September, things

looked a little bit better when $17.1 million was released from the Division of Regional Medical Programs. The Board of Directors, instead of submitting official notice to the state that they were going to terminate, kind of put the corporation in neutral gear and decided to wait.

It sounds like some story, but I am trying to get it in the right sequence so that you will understand.

As more money was released from DRMP, Doctor Zabatlyea had hired several people to the program staff; when it became clear that the lawsuit was won by the Regional Association, the Board of Trustees again, for the corporation, gave Doctor Zabatlyea another nod to go ahead and hire additional staff members.

During this time we made a site visit; Mr. Posta and I, in November 1973. The National Council was concerned about that; we made a site visit, we discussed this with Doctor Zabatlyea in February of this year. He indicated that he was going to resign from the corporation; two months ago he handed in his resignation and the grantee would not accept it.

He has increased his time back to 50 percent; he has rehired several of his staff. Several of the staff have been Project Directors with the Louisiana RMP when they worked for the CHP agency and have joined the staff, and what you see here basically are eight or nine -- maybe ten people; I

think it is 8.6 full-time equivalents, that they have now and they are asking for $1.25 million.

Doctor Cook, the Deputy Director, is 100 percent; he did come back to fill in the gaps when Doctor Zabatlyea was not there.

So it has been slow; the staff has been slow in building up. The present situation now is -that he is going to remain 50 percent. For how long I am not sure.

I would rather not comment on anything else.

MR. CHAMBLISS: I would if I may just make this observation to the Committee.

You should know that the staff has been very much concerned about this Region for some time, and that there is a concern beyond the staff as it relates to the CHP-RMP issues in Louisiana.

This has been one of the Regions that both Doctor Paul and Mr. Rubel have been concerned about the CHP-RMP relationships in, and I say that only to give, perhaps, Staff an opportunity to comment on those relationships between RMP and CHP and this Region.

DOCTOR WHITE: I should have mentioned that, too. That is apparent in the application, at least the communications from someof the CHP agencies, that people there are trying to stake out territories. They want to be the survivors and not RMP. They impose conditions on RMP, or try to,

WHD160 9

which I thought were totally unrealistic, in demanding that they come and present their proposals for review, and they were going to go after technical merit of the whole thing, as we were trying to avoid.

All that sort of thing instead of trying to determine -- yes, this is consonant with what we should be doing.

So I guess I also got up on my hind legs on that thinking, that I have invested time and effort in RMP and I would rather see them survive then CHP, and I shouldn't say that.

MR. ZIVLAVSKI: I would like to add some comments on the CHP comments. On the yellow sheets we have two paragraphs; one speaks to the New Orleans Health Planning Council, and the other speaks to the Northwest Louisiana area Health Planning Council.

The concern that Doctor White discussed concerning the New Orleans area; they notified the Project Directors the Friday evening before the CHP Monday morning meeting -- this one, their meeting on May 28th. Doctor Cook, the Deputy Director is meeting with the CHP agency, trying to resolve this.

The second concern is the Northwest area, which is made up of eight parishes in the Northwest part of the state. There is a three-page summary from this agency; basically it is probably the most negative letter in the whole application,

HD161

but when you read the whole letter you realize the territory that the Northwest area takes into account.

They have listed 12 projects here which they received, and they are all negative comments for these projects. None of these 12 projects fall into the area which their CHP agency has.

It is a mess, in that they received a b unch of project grant activities, which they really should not have received.

This will help you alleviate some of the concerns about the Northwest area. In addition, the Deputy Coordinator, Doctor Cook, is also meeting with this group on May 27th, I believe, to get this area straightened out.

They were favorable in three of the arthritis proposals, which this group is not reviewing, and they were favorable in another project, which again was not in their area anyway.

The two projects which head into the Shreveport area were continuation projects, and these were projects Number 42 and Project Number 44. These were continuation projects in this grant request in the Shreveport CHPH agency voted for approval for these two projects previously, and this is in the $71.1 million that was awarded for October to December, so I hope we can take care of Mr. Rubel's concerns in addressing the RAG and the CHP areas.

I think we have taken care of these major concerns.

MR. CHABMLISS: Thank you.

We would now entertain a recommendation, Doctor White.

DOCTOR WHITE: Well, unless you would prefer further discussion of the CHP issue, though I don't know that there is anything further to discuss. There is an obvious influence of some kind there that has to be resolved. I don't think this Committee can resolve it. We have already identified it anyway.

I think that RMP has done some good work down there; Doctor Zabatlyea was a dedicated fellow, and I think he has done a lot of work the CHP should have been doing, and there are some things to be completed, and I think it would be a shame to terminate it at this time, and therefore I would move that this be approved at the requested level, at $985,212.

DOCTOR MILLER: Second.

MR. CHAMBLISS: It has been moved and seconded that the level to be recommended for Louisiana be at $985,212.

Is there discussion?

I hear a call for the question. All those in favor?

(Chorus of "Aye")

Opposed?

(No response)

The "Aye's" have it; the motion is carried. This

panel has completed one-half of its work. I wish to commend it for its patience, its stamina and its participation, and I would also like to say to the Staff and to our Recorder that we appreciate your patience and stamina also.

(Whereupon, at 6:10 P.M. the Committee recessed to 8:30 A.M. May 23, 1974)

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